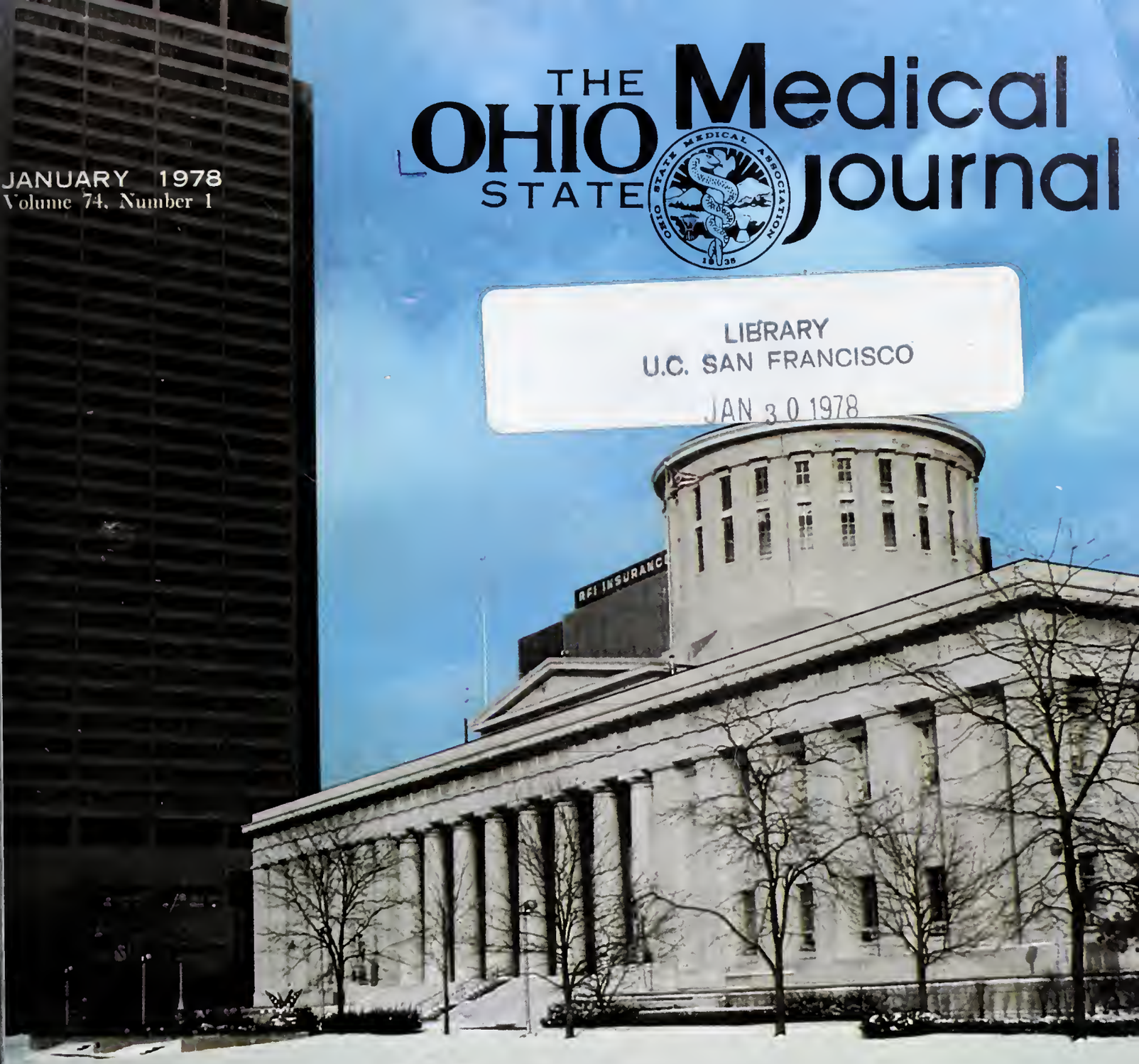

Digitized by the Internet Archive
in 2017 with funding from
The National Endowment for the Humanities and the Arcadia Fund

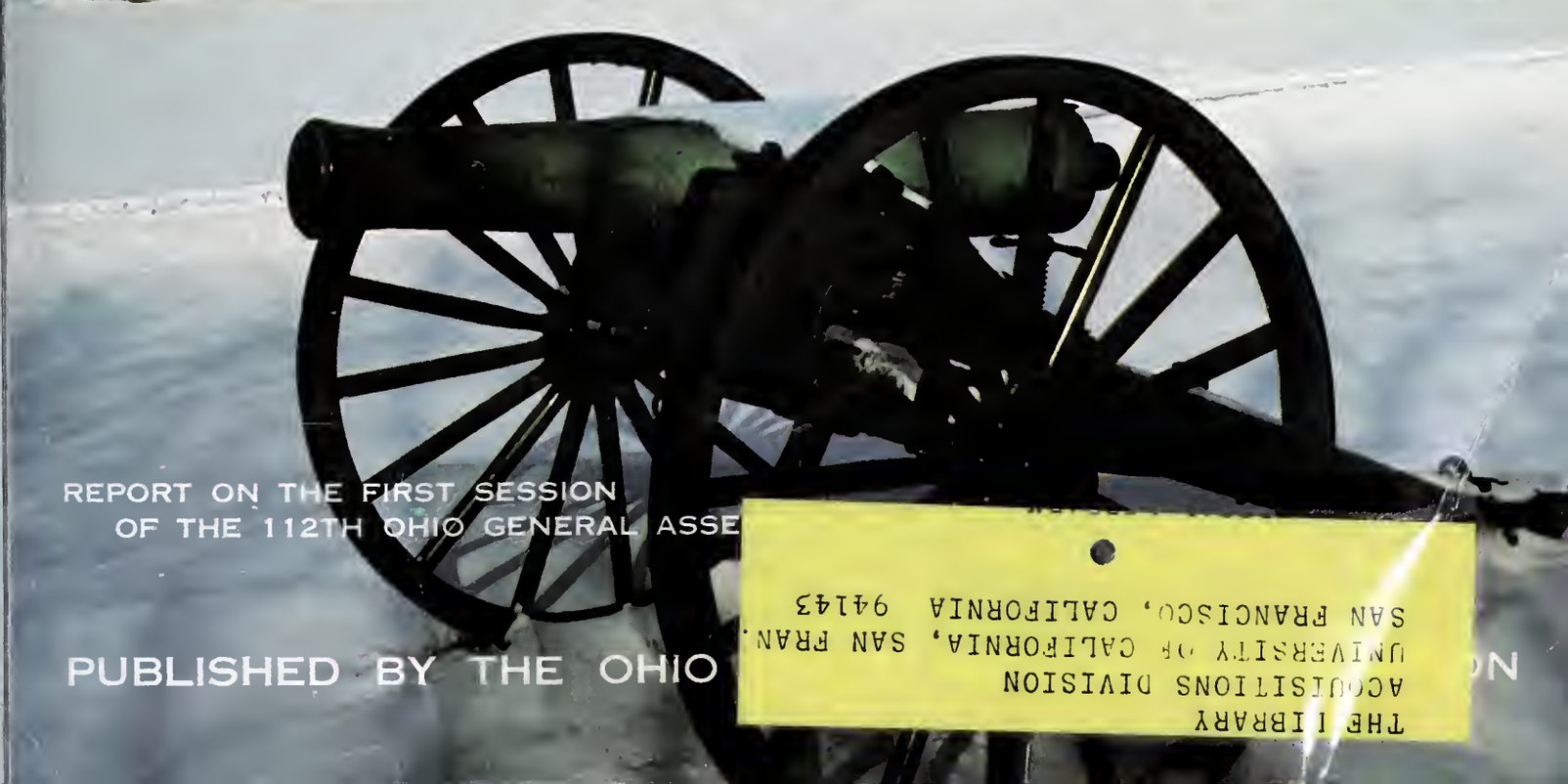
https://archive.org/details/ohiostatemedical74unse

JANUARY 1978
Volume 74, Number 1

THE OHIO STATE Medical Journal

LIBRARY
U.C. SAN FRANCISCO
JAN 30 1978





REPORT ON THE FIRST SESSION
OF THE 112TH OHIO GENERAL ASSE

THE LIBRARY
ACQUISITIONS DIVISION
UNIVERSITY OF CALIFORNIA, SAN FRAN.
SAN FRANCISCO, CALIFORNIA 94143

PUBLISHED BY THE OHIO ON



THE STRENGTH TO OVERCOME EXCESSIVE ANXIETY IN THE ELDERLY CARDIAC PATIENT.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

VALIUM®
(diazepam) IV

2-MG TABLETS B.I.D. OR T.I.D.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

OSMA OFFICERS
President
WILLIAM M. WELLS, M.D.
241 Hudson Avenue
Newark 13055
President-Elect
JOHN J. GAUGHAN, M.D.
7911 Detroit Avenue
Cleveland 44102
Past President
GEORGE N. BATES, M.D.
2102 Shenandoah Road
Toledo 13607
Secretary-Treasurer
ROBERT G. THOMAS, M.D.
630 East River Street
Elyria 44035

EDITORIAL STAFF
Consulting Medical Editor
RICHARD L. MEILING, M.D.
Managing Editor and Business Mgr.
HART F. PAGE
Executive Editor and Executive Business Manager
LINDA A. PORTERFIELD
Editorial Assistant
MARY LOU BRADY
Communications Editor
REBECCA J. DOLL
Continuing Medical Education Editor
GAIL E. DODSON
Ass't. Continuing Medical Education Editor
DAVID C. TORRENS
Federal Legislation Editor
CHARLES W. EDGAR
Field Service Editor
ROBERT E. HOLCOMB
Government Relations Editor
HERBERT E. GILLEN
Health Education Editor
ROBERT D. CLINGER
Membership Editor
KATHERINE E. WISSE
Organization Services Editor
JERRY J. CAMPBELL
State Legislation Editor
D. BRENT MULGREW, ESQ.
Ass't. State Legislation Editor
RICHARD A. AYISH

Address All Correspondence, Address Change, & Reprint Request (unless otherwise noted):
Executive Editor
The Ohio State Medical Journal
600 South High Street
Columbus, Ohio 43215
Phone: 614/228-6971

Published monthly under the direction of The Council for and by members of The Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215, a scientific society, nonprofit organization, with a definite membership for scientific and educational purposes.

1977 Subscription: $10 per year, single copy $1.50 (outside U.S. $13 and $2).

Entered as second class matter July 5, 1905, at the Post Office at Athens, Ohio, under the Act of Congress of March 3, 1879. Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918. Second-Class Postage Paid at Athens, Ohio.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertisers must conform to policies and regulations established by The Council of the Ohio State Medical Association.

Publication office: 900 East State Street, Athens, Ohio 45701.

Printed by
The Lawhead Press, Inc., Athens, Ohio

VOL. 74 JANUARY 1978 NO. 1

THE OHIO STATE Medical Journal

Clinical and Scientific Articles

SIX HUNDRED NINETY TOTAL HIP REPLACEMENTS A COMPARATIVE STUDY 23
Thomas H. Mallory, M.D.; Thomas L. Meyer, Jr., M.D.; and Jaren D. Bombach, M.D., Columbus

SURVEY OF OHIO PRIMARY PHYSICIANS A PROJECTION OF FUTURE NEEDS TO THE YEAR 2000 29
Lauren M. Brown, M.D., Akron, and Tennyson Williams, M.D., Dublin

CANCER EDUCATION SERIES: THE CANCER COMMITTEE 34
Tom F. Lewis, M.D., Columbus

Special Articles

RECIPIENTS OF THE OHIO STATE MEDICAL ASSOCIATION FIFTY-YEAR AWARDS 3

HIGHLIGHTS OF THE 1977 AMA INTERIM MEETING 4
H. William Porterfield, M.D., Delegate
With Linda A. Porterfield, Executive Editor

AGGRESSIVE MODERATION 13
AMA Presidential Address Delivered December 4, 1977
John H. Budd, M.D., AMA President

REPORT ON THE FIRST SESSION OF THE 112TH OHIO GENERAL ASSEMBLY 41
D. Brent Mulgrew, J.D., Director, and Richard A. Ayish, Assistant Director, OSMA Department of State Legislation

TELEVISION VIOLENCE AND THE CHILD 67
Ingrid May, OSMA Auxiliary President

Features

Continuing Education Programs...16
Legislative Update — Federal....20
Journal Advertisers.....27
News 36
Obituaries 49
Proceedings of the Council.....50
Colleagues in the News.....58
New Members 66
Classified Ads.....69
OSMA Placement Service Ads.....72

COVER: D. Brent Mulgrew, J.D., Director of the OSMA Department of State Legislation, took this photograph of the Ohio Statehouse. Mr. Mulgrew is also a member of *The Journal* Photography Exhibit Committee. (See the October and December 1977 issues of *The Journal* for details about the Photography Exhibit.)

344260

Rhine River Adventure

Ohio State Medical Association

Departing Columbus on June 19
Returning on June 29, 1978







. . . not all of Europe's masterpieces are in museums. There's magnificent old-world architecture and beautiful Rhineland countryside that inspired the world's greatest artists. Rich Rhine wines and mouthwatering European desserts, the inspirations of gourmet chefs, for your dining pleasures.

Friendly Belgian women selling bright flowers and smiling German men puffing on aromatic pipes that inspire a feeling of European hospitality.

Rollicking laughter and oompah bands at convivial German inns and subdued conversations of couples in candlelit, elegant restaurants, are inspirations to join in the nightlife.

This year find your own excitement on our do-as-you-please holiday through the heart of Europe... BRUSSELS, Belgium... RHINE RIVER Cruise... MUNICH, Germany.

Our Rhine River Adventure price $1298 includes comfortable direct PAN AM flights. Deluxe accommodations in each city and aboard the M/S BRITANNIA. Full American breakfasts, dinners at a selection of the finest restaurants, and international cuisine aboard ship. Generous 70 pound luggage allowance and the many more amenities that will make this an unusual travel experience.

Send to: Ohio State Medical Association
600 South High Street
Columbus, Ohio 43215

Enclosed is my check for $ _____ ($100 per person) as deposit.

Names _____

Address _____

City _____ State _____ Zip _____

Area Code _____ Phone _____

Space Strictly Limited—Make Reservations Now

A Non-Regimented INTRAV® Deluxe Adventure

Recipients of the Ohio State Medical Association Fifty-Year Awards

The following physicians have practiced medicine for 50 or more years. In honor of this achievement, the OSMA has presented each physician a plaque and a pin.

ATHENS
Charles R. Hoskins
Louisa E. Lorber Omelsky

BELMONT
William B. Stryker

BUTLER
David R. Scott

CLERMONT
Pearl Zeek-Minning

COSHOCTON
Roy D. Hildebrand

CUYAHOGA
Joseph C. Amersbach
Charles Berns
Otto W. Blum
Rudolph Bognar
Edith P. Brown
Lewis W. Chalfin
David A. Chambers
William C. Compton
Henry A. Crawford
Charles D. Deme
Edward P. Friedl
Howard M. Gans
Virgil S. Glass
John M. Hamilton
Irwin C. Hanger
John H. Hess
Arthur J. Horesh
Ernest Kohner
Tibor Krompaszky
Harry J. Kumin
Hyman S. Lieberman
David Lubin
James J. Marek
Salvator G. Marino
Gustav G. Picard
Casimir Radecki
Albert H. Reed
Harry H. Robinson
William H. Schaller
John W. Schauer
H. Charles Schock
Laszlo Szentendrey
John J. Zickes

FRANKLIN
Robert H. Browning
Maurice G. Buckles
Howard De Bosse Giles
George J. Heer
Raymond B. Hudson
Robert M. Zollinger

GEAUGA
Theodore Mackiw

GREENE
Theodore H. Winans

GUERNSEY
William L. Denny

HAMILTON
James Wm. S. Calvert
Phillip Cohn
Helen J. Schiel Compton
Merlin L. Cooper
Hobart R. Fullerton
Mitchell N. Ganim
John H. Hunt
Harry E. Landt
Justin E. McCarthy
Walter Mueller
Clyde S. Roof
Leslie J. Schradin
Cyril E. Schrimpf
Norbert F. Slomer

HARRISON
Richard W. Weiser

JEFFERSON
Stephen A. Harris
Max H. Rosenblum

LAKE
Alfred C. Mahan

LORAIN
Stanley J. Birkbeck

LUCAS
Nolen T. Barnes
Albert L. Bershon
John F. Buck
Edward A. Gribbin
Cletus A. Grothjan
Eugene A. Ockuly
Cornelius J. A. Paule
N. Carman Spencer
Dudley M. Stewart
James F. Whitacre

MAHONING
James B. Birch
Leonard A. Blum
Chester S. Lowendorf
John N. McCann
Morris W. Neidus
Gordon G. Nelson
Saul J. Tamarkin
Walter J. Weickenand
Carl H. Weidenmier

MARION
Arthur L. Osborn

MIAMI
Hugh Wellmeier

MONTGOMERY
William R. Hochwalt
Harold M. James
Lawrence J. Lohr
James L. Sagebiel
Theodore H. Sills

PICKAWAY
Walter F. Heine

STARK
Ian B. Hamilton

SUMMIT
John D. Brumbaugh
Arthur F. Dorner
Everett A. Irish
J. Walter Johnson
Cletus T. McCormish
Thayer L. Parry
Bedford N. Riddle
Wilbur C. Robart

WASHINGTON
Wilbur D. Turner

WOOD
Halford E. Whitacre

Highlights of the 1977 AMA Interim Meeting

December 4-7, Chicago

H. William Porterfield, M.D., Delegate
With Linda A. Porterfield, Executive Editor

For the first time, the AMA House of Delegates Interim Meeting was held separately from the scientific programs. This change in format had been approved two years previously to permit the AMA to evolve regional educational programs geared to the needs for continuing medical education.

Your Ohio Delegation to the AMA met initially on Sunday morning, December 4, to review significant, proposed reports and resolutions to be considered by the House. The following Delegates and Alternate Delegates attended the 1977 Interim Meeting: Delegates— P. John Robechek, M.D., Cleveland, Chairman; Oscar W. Clarke, M.D., Gallipolis, Vice-Chairman; Henry A. Crawford, M.D.,* Cleveland; Jerry L. Hammon, M.D., Dayton; Harry K. Hines, M.D., Cincinnati; W. J. Lewis, M.D., Dayton; H. William Porterfield, M.D., Columbus; Jack Schreiber, M.D., Canfield; and Robert N. Smith, M.D., Washington, D.C. Alternate Delegates— John E. Albers, M.D., Cincinnati; Dwight L. Becker, M.D., Lima; Theodore J. Castele, M.D., Cleveland; Richard L. Fulton, M.D., Columbus; John J. Gaughan, M.D., Cleveland; B. Leslie Huffman, M.D., Maumee; and Robert G. Thomas, M.D., Elyria.

The opening session of the AMA House of Delegates consisted of submission of reports and resolutions to be considered and was highlighted by an outstanding presidential address by Ohio's own John H. Budd, M.D. (See AMA Presidential Address this issue.) Luis M. Perez, M.D., of Sanford, Florida was the recipient of the Dr. Benjamin Rush Bicentennial Award for outstanding community and civic activities. Dr. Perez, a naturalized American citizen who came from Cuba, gave a moving and inspiring acceptance speech.

On Monday, December 5, the Ohio Delegation participated in and monitored each of eight reference committees. The entire afternoon was set aside for discussion of the AMA Comprehensive Health Insurance Act of 1977 (HR 818) which has been before Congress this year. Considerable discussion was heard regarding the feasibility of an AMA-sponsored legislative program. Subsequently, the House of Delegates continued their support of the current bill by a four-to-one vote.

The following are highlights from the eight reference committees and the actions taken by the House of Delegates.

Specialty-Society Representation In AMA House of Delegates

The report of the Reference Committee on Amendments to Constitution and Bylaws was highlighted by a lengthy presentation and debate on the matter of specialty-society representation. Currently, there are 28 delegates sitting in the House representing specialty societies. These delegates are selected through the section council mechanism which brings together specialty groups with common interests and results in a delegate being selected from each of those groups.

The discussion ranged from representation based on

(continued on page 6)



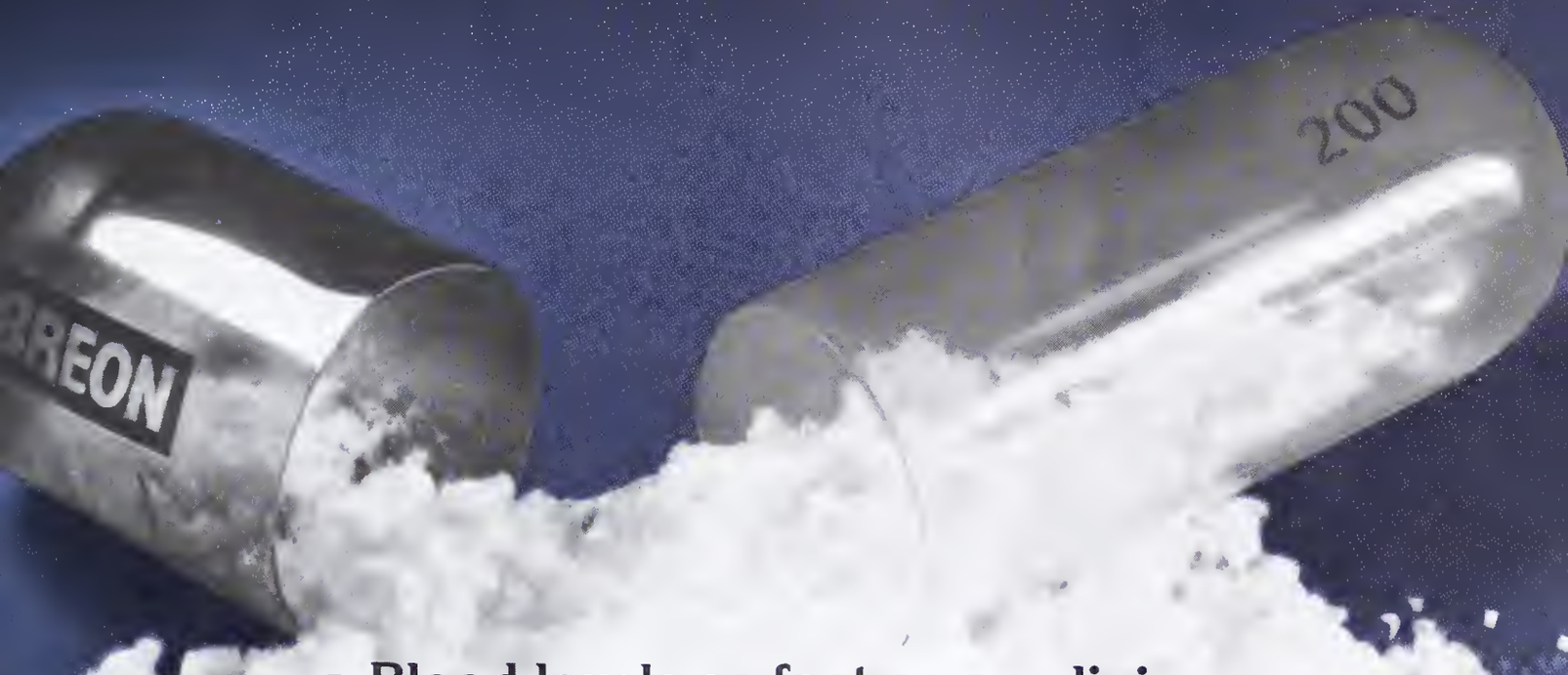
LEFT TO RIGHT: Luis M. Perez, M.D., recipient of the Benjamin Rush Award, and John H. Budd, M.D., President of the AMA. (Photo by Joe Fletcher of the AMA Staff.)

*The Editors of *The Journal* are saddened to report that Dr. Crawford died shortly after returning to his home from the AMA Interim Meeting. A Past President of the OSMA, Dr. Crawford was also President of the Ohio State Medical Board at the time of his death.

A Difference in Theophylline Therapy

micro-pulverized BRONKODYL® Capsules

brand of theophylline, USP anhydrous



- **Blood levels as fast as an elixir**
- **With minimal gastric irritation***

*Please see complete prescribing information, a summary of which follows.

DESCRIPTION:
Each green and white hard gelatin capsule contains theophylline USP anhydrous, 200 mg., in a micro-pulverized form. Each brown and white hard gelatin capsule contains 100 mg. The elixir contains 80 mg. theophylline per 15 ml. in a 20% alcohol elixir (approximately 20 calories, 0.9 gm carbohydrate per tablespoonful).

ACTION: Theophylline is a methylxanthine which relaxes the smooth musculature of the bronchioles through its inhibition of the conversion of cyclic adenosine monophosphate to adenosine monophosphate by phosphodiesterase. It also has diuretic, cardiotonic, and CNS stimulant effects.

INDICATIONS: Bronkodyl is indicated for symptomatic relaxation of bronchiolar spasm in the chronic obstructive bronchopulmonary diseases; e.g., bronchial asthma, chronic bronchitis and pulmonary emphysema.

CONTRAINDICATIONS: Bronkodyl is contraindicated in persons known to have had serious idiosyncratic responses to theophylline, its salts, or the other methylxanthines, theobromine, or caffeine and may be contraindicated in peptic ulcer.

WARNINGS: All methylxanthines should be used with caution in children and in others who are currently taking bronchodilator products, especially in rectal dosage form, which may contain theophylline or related drugs.

USAGE IN PREGNANCY: Although theophylline has been used for many years, with no evidence of adverse fetal effect or teratogenicity, its safety in pregnancy has not been established. Therefore use of Bronkodyl during lactation or in women of childbearing potential requires that possible benefits of the drug be weighed against possible hazards to fetus or child.

PRECAUTIONS: Bronkodyl should be used with caution in patients with cardiac or circulatory disease.

ADVERSE REACTIONS: Gastrointestinal: Epigastric distress, nausea, vomiting. Cardiovascular: palpitations. CNS: Insomnia, restlessness, irritability, convulsion.

DOSAGE AND ADMINISTRATION: Adults: Usual dosage of Bronkodyl is 200 mg. every 6 hours (four doses in each 24 hours). This dosage may be adjusted to reflect individual clinical response as an indication of slow or rapid metabolism of the drug. If adverse reactions are encountered, each dose may be reduced, or the interval between doses may be lengthened, or both. If clinical response is not satisfactory, indicating possible rapid inactivation of the drug, dosage may be gradually increased to achieve the desired response. In some instances of either too slow or too rapid metabolism, plasma levels of theophylline should be determined and dosage adjusted accordingly to achieve levels above 10 mcg/ml, but not to exceed 20 mcg/ml.

Dosage in Children: Usual dosage should be based on administration of 10 mg per kg per 24 hours, divided in 4 doses per day, given every 6 hours. As this may not be possible with use of the capsules, Bronkodyl elixir may be used. Theophylline saliva levels (approximately 60% of simultaneous blood levels), may facilitate dosage adjustments, especially in children, to obtain appropriate response.

HOW SUPPLIED:
Bronkodyl 100 mg., brown and white capsules in 100's, Code #1831.
Bronkodyl 200 mg., green and white capsules in 100's, Code #1833.
Bronkodyl Elixir, 80 mg. per 15 ml, in pints, Code #1835.

BREON LABORATORIES INC.
90 Park Avenue, New York, N.Y. 10016

membership of specialties to retaining the status quo. The recommendation of the Council on Long Range Planning and Development provided the base for the ultimate solution: (1) The section council delegates will remain seated to the conclusion of the present interim meeting; (2) By-law amendments relating to the changes will take effect at the conclusion of the current meeting; (3) Between the conclusion of the 1977 Interim Meeting and the opening of the June 1978 meeting, national Medical specialty societies may apply to send a delegate to the House.

In order to qualify to have a representative to the AMA House of Delegates, a specialty society will have to meet the following criteria: (1) Be currently represented on an AMA Section Council and have 1,000 or more AMA members; (2) Be currently represented on an AMA Section Council, have fewer than 1,000 AMA members, and have an approved examining board listed in the Liaison Committee on Graduate Medical Education's Directory of Accredited Residencies; or (3) Not be currently represented on an AMA Section Council but be granted representation upon recommendation by the AMA Board of Trustees and approval of the House of Delegates.

Each specialty society granted representation will have one delegate who will serve a term of two years.

Full-Time President

The issue of a full-time President of the AMA was resurrected, and the House chose to follow the existing format. At the same time, they turned down a recommendation that the office of Executive Vice-President be titled Executive President.

Medical Service Matters

Reference Committee A handled matters relating to medical service. A final report of the Council on Medical Service and the Judicial Council on "Confidentiality of Computerized Patient Information" was adopted. This report defines guidelines to assist computer service organizations and physicians in maintaining confidentiality of medical record information stored in computerized data bases.

The information regarding draft legislation directed toward solving the problem of profiles for new physicians under Medicare was filed. It is hoped that this legislation can be submitted and adopted as an amendment to the Medicare law. A report from the Council on Medical Service regarding the reimbursement difficulties for rural and urban physicians was adopted, and efforts to achieve change in this system will be undertaken. The matter of certification procedures under Medicare was discussed

TREAT THE SYMPTOMS IN THE GERIATRIC PATIENT

APATHY • IRRITABILITY
FORGETFULNESS • CONFUSION



Cerebro-Nicin® CAPSULES

A GENTLE CEREBRAL STIMULANT & VASODILATOR FOR GERIATRIC PATIENTS

Each CEREBRO-NICIN capsule contains:
Pentylenetetrazole .....100 mg. • Nicotinic Acid ...100 mg.
Ascorbic Acid .....100 mg. • Thiamine. HCl .....25 mg.
I-Glutamic Acid .....50 mg. • Niacinamide .....5 mg.
Riboflavin .....2 mg. • Pyridoxine HCl .....3 mg.
AVAILABLE: Bottles 100, 500, 1000
SIOE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and abdominal cramps. The reaction is usually transient.
INDICATIONS: As a cerebral stimulant and vasodilator.
RECOMMENOED GERIATRIC OOSAGE: One capsule three times daily adjusted to the individual patient.
WARNING: Overdosage may cause muscle tremor and convulsions.
CONTRAINDICATIONS: Epilepsy or low convulsive threshold.
CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

Write for literature and samples . . .
BROWN THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057

extensively in view of Report R of the Council on Medical Service. This matter, along with that included in Report F of the same council, makes clear the fact that physicians are not legally responsible for certifications under Medicare and Medicaid. However, the reports and the Reference Committee emphasized the fact that it is important that physicians participate in the certification process because of the medical necessity of the services rendered, thereby not abrogating their responsibilities to other health professionals.

Report Q of the Board of Trustees was filed. It states that the AMA will develop legislation amending the Medicaid law to provide the same physician-billing option as provided under Medicare.

The abortion issue came up again through a resolution which stated: ". . . the AMA advise the United States Congress, the Department of Health, Education, and Welfare, and all other applicable third party payors, that elective abortion services rendered under Medicaid and in other third party payment programs would be recognized as compensable services." This resolution was adopted by the House and was referred to the Board of Trustees for in-depth study, with a report to be made at the June 1978 meeting.

Ohio's "Medicaid-Provider Agreement" resolution was referred to the Board of Trustees for study by the Councils on Medical Service and on Legislation for a report at the 1978 Annual Meeting. Due to state-to-state discrepancies in application of this Medicaid-Provider Agreement, clarification and further recommendation is necessary.

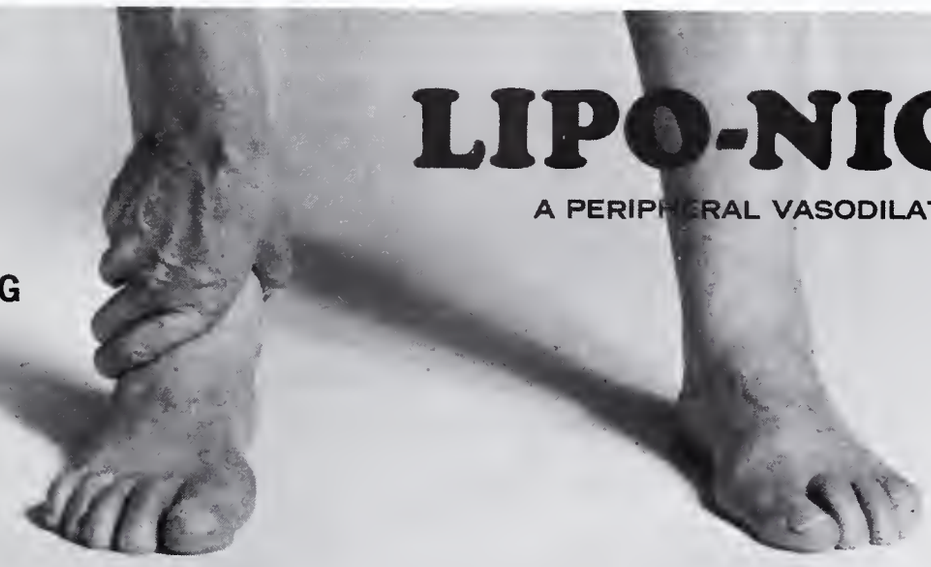
Professional Standards Review Organizations

Professional standards review organizations (PSRO) were again a topic of discussion, but in a much calmer manner than the tumultous discussions held in years past. The House affirmed: ". . . that the AMA reaffirm its stand that PSRO-derived information remain confidential and that it not directly or indirectly identify the specific hospital, patient or physician." The House also adopted a resolution that read in part: ". . . the AMA, through its Council on Medical Service and other appropriate units, continue to monitor and evaluate data forthcoming from studies of PSRO program effectiveness, and convey the results of its evaluation periodically to the House of Delegates."

A resolution addressing itself to third-party carrier discrimination against "nonparticipating" physicians was passed by the House. This resolution referred to all insur-

(continued on page 8)

COLD FEET
LEG CRAMPS
TINNITUS
DISCOMFORT ON STANDING



LIPO-NICIN
A PERIPHERAL VASODILATOR

IMMEDIATE or GRADUAL
nicotinic acid therapy

IMMEDIATE RELEASE

LIPO-NICIN/100 mg.
Each blue tablet contains:
Nicotinic Acid .....100 mg.
Niacinamide ..... 75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .. 25 mg.
Riboflavin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6).. 10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500, 1000.

LIPO-NICIN/250 mg.
Each yellow tablet contains:
Nicotinic Acid .....250 mg.
Niacinemide ..... 75 mg.
Ascorbic Acid .....150 mg.
Thiemine HCL (B-1) .. 25 mg.
Riboflavin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6).. 10 mg.
DOSE: 1 to 3 teblets deily.
AVAILABLE: Bottles of 100, 500, 1000.

GRADUAL RELEASE

LIPO-NICIN/300 mg.
Each time-release capsule contains:
Nicotinic Acid .....300 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (H-1) .. 25 mg.
Riboflavin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6).. 10 mg.
In a special base of prolonged therapeutic effect.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant edministration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient. Side Effects: Transient flushing and feeling of wermth seldom require discontinuation of the drug. Transient headache, itching end tingling, skin rash, allergies and gastric disturbance mey occur. Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and petients with glaucoma, severe diebetes, impeired liver function, peptic ulcers, end arterial bleeding.

BROWN THE BROWN PHARMACEUTICAL CO., INC. 2500 West Sixth Street, Los Angeles, California 90057
Write for Literature and Samples
REFER TO PDR

ance carriers who make this discrimination in reimbursement.

The issue raised by a resolution objecting to Aetna Life and Casualty's advertising campaign, in which it alluded to high cost factors as being physician related. was resolved by adopting the report of the Council on Medical Service. This report voiced objections to this concept and recommended physician monitoring of this problem. It was emphasized that the AMA's public education advertising program is designed to overcome some of these image problems.

Physicians Assistants

The issue of restrictions on the use of assistants to the physicians was addressed in Report K of the Council on Medical Service, which was adopted. The House also affirmed that provisions in state legislation, which prohibit the performance— consistent with good medical practice— of allied health personnel working as assistant to and under the direction and control of physicians, restrict the ability of the physician to use effectively such personnel in patient care.

Health Planning Guidelines

The problem of health planning was addressed once again, with objections to the current legislation continuing. The AMA will continue efforts to assist local physicians and organizations in influencing the implementation of the proposed health planning regulations. The AMA will also continue efforts jointly with the American Hospital Association to facilitate physicians receiving copies of patients' hospital bills.

This important issue was addressed in Reolution 57. The House voiced very strong opposition to the proposed health planning guidelines. It was noted that the Board of Trustees of the AMA has already testified against these regulations. A special report from the Board of Trustees regarding the studies of the British National Health Service was accepted and applauded.

The AMA has sponsored four delegations to the British system, during which times 82 persons have participated representing 30 states. This has given many key members of the organization a firsthand look at the British system and has allowed for a much more significant discussion of the system. A fifth tour is planned in spring 1978 in an effort to expose key members of congressional staffs and national media people to this system. The Board was commended for this activity.

Comprehensive Health Insurance

Reference Committee B dealt with legislative matters. The highlight of this committee's activities was the AMA's position on comprehensive health insurance. The AMA's proposed bill, HR 1818, has been the vehicle through which the AMA has introduced their concepts on the matter to Congress. The Council on Legislation drafted this bill a year ago and worked to have it introduced. In the last three sessions of the House of Delegates, the matter of the propriety of any legislation being supported by the AMA was thoroughly discussed. The delegates reached the decision that this bill was necessary to give spokesmen who agreed with the AMA's position a base from which to function in the legislative process. The current House recognized that the bill would soon die on its own and that some new effort would have to be exerted. On a four-to-one vote, the delegates supported the present position of HR 1818 and the continued presentation of legislative proposals on this matter to the United States Congress.

The House adopted the Board of Trustees' report regarding the support of the health professions' Educational Assistance Act which affects foreign medical graduates who transfer to U.S. schools. This legislation would reduce the requirement for foreign medical student acceptance by U.S. medical schools to a 5 percent increase in class enrollment at the third-year level.

A report from the Board of Trustees recommending the development of draft federal legislation to require the preparation and publication of economic impact analyses for all federal regulations promulgated was adopted. It was also recommended that model state legislation be developed in this same regard.

Certificate of Need

The issue of certificate of need as applied to physicians' offices was the subject of Resolution 38. The House affirmed that ". . . the AMA be prepared to consider joining with a state medical society, at the request of the society, that commences an appropriate legal action challenging a state certificate of need law that includes physicians' offices in that state." This resolution was then referred to the Board of Trustees and on to the Council on Legislation for the development of legislative language.

The issue of certificate of need for federal hospitals and health maintenance organizations was addressed and acted upon by passage of a substitute resolution which stated: "that the AMA have instituted and strongly support passage of legislation which would place all government institutions, whether state, county, municipal or, except for Department of Defense institutions, federal, under the same health planning, PSRO and other federally mandated health care requirements which are imposed upon private institutions by federal law."

Items regarding confidentiality of peer review and PSRO data were passed. It was recommended that the AMA oppose any attempts to change current law or regulations pertaining to confidentiality of PSRO data; that the AMA have introduced in the Congress legislation which would provide for the protection of confidentiality of medical society peer review and disciplinary records; and that the AMA would support legislation allowing Congressional overview of regulations pertaining to PSRO and utilization review. This last position was taken since

it was noted that Congressional committees already have oversight jurisdiction over federal health programs.

Educational Matters

Reference Committee C addresed itself to educational matters. A report from the Council on Medical Education Liaison Committee on Continuing Medical Education (LCCME) was adopted. This report requests that at least three state medical society continuing medical education (CME) chairmen be included in the LCCME. Through this membership and additional cooperation between state departments of CME, more consistency in CME throughout the U.S. can be affected. The matter of recording CME credits was again considered; and the AMA was asked to proceed as rapidly as possible in the development of their credit records system since many of the states are in the process of creating similar programs. It is hoped that duplication can be avoided.

The issue of the economics of health care and the need to make medical students and house staff aware of this cost factor was addressed in Resolutions 21 and 47. A substitute resolution was passed stating that "the AMA through its representatives on the Liaison Committee on Medical Education encourage all medical schools to institute or augment educational programs designed to increase the understanding and awareness of medical students, house staff, and faculty, of the cost of medical care," and. . . . "that the AMA representatives on the Liaison Committee on Graduate Medical Education and the Liaison Committee on Continuing Medical Education encourage all programs of graduate and continuing medical education to increase the awareness and understanding of all physicians of the costs of health care."

The matter of nutrition courses in all levels of education was discussed. The House affirmed "that the AMA recommend the teaching of adequate nutrition courses in elementary and high schools" and "that the AMA representation of LCCME work towards enhancement of the teaching of nutrition in medical schools."

Report K of the Council on Medical Education addressed the problem of providing for a broad first-year graduate medical education since the internship no longer exists. It was approved, and efforts will be made to implement this type of program. Revisions were approved in the essentials of approved residencies in family practice, ophthalmology, therapeutic radiology, and pediatrics.

The problem of physician recertification was addressed; and following lengthy discussion, it was approved that an Ad Hoc Committee of the Council on Medical Education be formed to study the recertification matter. This Committee should serve as a coordinating influence to bring together the many fragmented approaches, finally guiding the profession to establish the best method by which to document the continuing competence of the practicing physician. The formation of an Ad Hoc Committee on Foreign Medical Graduates was approved in

(continued on page 10)



LEFT TO RIGHT: The Ohio Delegation seated in the House of Delegates— Row One: P. John Robechek, M.D.; Oscar W. Clarke, M.D.; H. William Porterfield, M.D.; W J. Lewis, M.D.; and Theodore J. Castele, M.D. Row Two: Robert N. Smith, M.D.,; Jack Schreiber, M.D.; Harry K. Hines, M.D.; and Jerry L. Hammon, M.D. (Photo by Fletcher.)

AMA Report *(continued)*

an effort to solve some of the problems that exist in this area.

Hospital Issues

Reference Committee D dealt with the problems relating to hospital issues. Report H of the Board of Trustees, relating to the primary responsibility for hospitalized patients, was the result of a year and a half of discussions regarding the matter of physician responsibility and the responsibilities of nonphysician care providers. State laws vary as to which nonphysician providers may function in the hospital environment. However, the need to maintain quality of care, with local medical staff and hospital governing board enforcement of rules and procedures which assure high standards of care for all patients irrespective of the provider service, is essential. The Board of Trustees' Report H contains the final recommendations, which are available upon request.

A lengthy report regarding guidelines for physicians attending patients in long-term-care facilities was presented and approved with some modification. These guidelines contain 22 items which also can be obtained upon request.

Report J of the Council on Medical Service spoke to the issue of physicians' offices in hospital-owned buildings. This report was adopted with an additional statement that "Physician rental arrangements should be on a fixed fee and not on a percentage basis."

Teaching of House Staff

The problems relating to professional ethics and the legality of special arrangements for teaching of house staff were extensively discussed in reference committee, and a substitute resolution was adopted by the House stating:



LEFT TO RIGHT: Max H. Parrott, M.D., Chairman of the National Committee on the Cost of Medical Care, and John H. Budd, M.D. (Photo by Fletcher.)

RESOLVED, That the AMA oppose the mandatory delegation for the diagnosis and treatment of the private patient primarily to the house staff physicians in the teaching hospital, or any other hospital setting; and be it further

RESOLVED, That the private physician should for the purpose of intern and resident medical training allow the house staff to write orders on his private patient, subject to the physician's consent. . . .

The issue of the liability of the hospital medical staff physician when he renders obligatory services as an agent for a hospital corporation was clarified in an adopted resolution. It asks the AMA to seek an immediate modification in hospital accreditation standards that unnecessarily expose the hospital medical staff physician to personal medical liability in performing services as an agent of the hospital.

Scientific Matters

Reference Committee E dealt with scientific matters. It first considered the problem of patient package inserts by urging that the AMA oppose the mandatory insertion of these instructional materials. The problem arises primarily when the instructional material inserted by the manufacturer issues statements which are contrary to the physician's patient instructions.

Report D of the Council on Scientific Affairs dealt with the health aspects of marijuana use. This report recommends discouragement of the use of marijuana, concentrated research to determine the consequences of long-term use, and reduction in the severity of penalties and laws governing possession of marijuana for personal use. This report, with some editorial modifications, was adopted.

There were four resolutions pertaining to the definition of death and the recognition of brain death. The House adopted a resolution which stated:

RESOLVED, That the AMA reaffirm the established policy that "death shall be determined by the clinical judgment of the physician using the necessary available and currently accepted criteria" and the "permanent and irreversible cessation of function of the brain constitutes one of the various criteria which can be used in the medical diagnosis of death". . . .

Resolution 71 asked the AMA to urge stricter enforcement of laws punishing violent crimes. The resolution itself was not adopted, but the Reference Committee called the House's attention to Section 10 of the *Principles of Medical Ethics* which provides:

> The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

Another resolution dealt with active Association support of the promotion of exercise. This principle was approved along with a request that the AMA Board of Trustees consider the feasibility of developing a public and professional education program emphasizing the advantage of regular exercise and report this program back to the House in June 1978.

"California cardiologists offer advice on how to deal with liquid protein-diet side effects... major medical centers report on the emerging clinical role of ultrasound... pediatricians would ban trampolines... proposed legislation gives the FDA more authority over physician-prescribing..."

Important things are happening that you should know about right away. You'll find them on your desk every two weeks in Medical World News, the newsmagazine of medicine.

Read this one first.

medical world news

A McGraw-Hill publication

McGraw-Hill



1978 Annual Meeting, Ohio State Medical Association

DO YOU HAVE AN EXHIBIT or know of an exhibit which is of scientific interest? If you do, the Ohio State Medical Association Annual Meeting is just the place to display it. We are now accepting applications for the 1978 OSMA Annual Meeting. Those eligible to apply are as follows: (1) Exhibits by Ohio physicians, Ohio medical schools, hospitals or similar organizations; (2) Out-of-state physicians or out-of-state agencies on invitation; (3) Voluntary health organizations.

Exhibits will be set up and viewed at the Dayton Convention and Exposition Center, 22 Dave Hall Plaza, Dayton, Ohio. Exhibit Days and Times will be as follows: Monday, May 8 — 12 NOON - 4:30 PM; Tuesday, May 9 — 9 AM - 4:30 PM; and Wednesday, May 10 — 9 AM - 12 NOON.

Mail applications to the attention of Vincent T. La Maida, M.D., Chairman, Subcommittee on Scientific Exhibits, Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215.

APPLICATION FOR SPACE
SCIENTIFIC EXHIBITS

1978 Annual Meeting, Ohio State Medical Association

Dayton Convention and Exposition Center, Dayton, May 8, 9, and 10

__ I am interested in receiving an application and details regarding space for a scientific exhibit at the 1978 OSMA Annual Meeting. Please send to:

Name_____

Address_____

City_____ State_____ Zip_____

Aggressive Moderation

AMA Presidential Address Delivered December 4, 1977

John H. Budd, M.D., Cleveland
AMA President

You and I live at a time when patterns of attitude and action are not fully understood unless they have a label. There is no easy way to label the general approaches of this federation of ours. And certainly they are widely misunderstood and misrepresented. Compounding all the false impressions are the complexity of the issues we deal with the diversity of what we propose and oppose. In the absence of other labels, I suggest that the stance of the American Medical Association be called "aggressive moderation." That may sound like a contradiction in terms, but I think it is not. Moderation, like medicine taken in the proper dosage, can be the only effective remedy for a problem. Tempering, after all, is what converts soft iron into hard steel. The Roman author, Horace, observed "there is a proper measure in all things, certain limits beyond which, and short of which, right is not to be found."

Many of the efforts of our federation are directed at finding that proper measure. And in a nation as interdependent as ours, it has to be found. For the most part, the very development of our nation has followed the midstream rather than extremes. Granted that many people in other fields of endeavor are waving wild banners and making headlines with them.

In our own ranks of medicine, there are factions that indulge in what could be called knee-jerk reactions to everything the federal government does. They may entertain the illusion that those knee-jerks are sharp kicks. However, we have to recognize that the government, often as it autocratically acts on its own, does not act solely for itself. We have to recognize that on such issues as National Health Insurance and medical costs, it will be responding to what it considers desirable to labor, to business, and to the general public.

Indeed, I believe that on those issues the government is acting in an informal coalition with significant portions of labor and industry. Government, industry, and labor each want a greater share of the Gross National Product and together they could more effectively obtain it.

Public spending now constitutes 37 percent of the GNP, compared with 26 percent two decades ago. The new Department of Energy, with its $10.6 billion budget, is evidence that government's hunger has not been appeased. Industry wants more of the GNP for net income and labor for wages. Their joint purpose is exemplified by the makeup of the Labor-Management Group cochaired by AFL-CIO President George Meany and the General Electric Board Chairman Reginald H. Jones.

Other industries represented in this group, which has released a position paper on medical costs, include General Motors, DuPont, Bechtel, U.S. Steel, Mobil Oil, and Sears Roebuck. An obvious means of giving labor, industry, and government a greater share of the Gross National Product is greater federal intervention in health services and in expenditures for those services. Undoubtedly they are perturbed that the national health outlay is $139 billion a year and is on the upswing.

However, the impetus for federal inroads cannot be attributed solely to forces that have an ax to grind. The general public has to be considered. While largely pleased with the care it receives, 67 percent of the public feels that National Health Insurance is needed according to a recent Gallup poll. And an equal percentage regards cost and cost-related issues as the most pressing health-care issues, according to a survey by Market Opinion Research.

So what we physicians have to face up to is not just a swollen federal government but a general groundswell. And if we fail to recognize that reality, we're just walking in the dark and are sure to stumble. As Indiana Governor Otis R. Bowen, M.D., wrote a fellow physician on a specific clinical issue, we cannot get by with negativism and griping. We have to be positive, positive in a manner

(continued on page 14)

Presidential Address *(continued)*

that simultaneously does justice to the public's interests and our professional rights. Our federation has to act as a balance wheel in terms of those interests and those rights. We have to be moderates. And the moderation has to be as aggressive, as forceful, as government's tendency toward excess.

Let us not suppose that any National Health Insurance proposal from President Carter will be lacking in excess. Let us not suppose that on Capitol Hill it would meet the same Charge of the Light Brigade fate as the derring-do of his first year in office. Instead, we must assume that the imminence of the 1978 elections, a precursor of the 1980 elections, will stimulate better teamwork between White House and Congress. Many voters might be skeptical of a Congress that repeatedly rejects White House proposals just as they are skeptical of any President who chronically vetoes Congressional bills.

We do not have any idea what form the Administration's NHI proposal would take. Options range from tax credits for the purchase of private insurance to the tax-paid National Health Service inherent in the Kennedy-Corman bill. Without elaborating, the President himself has called for "the phasing in of a workable national health insurance system." We have to ask ourselves what the ultimate phase would be. Strangulation on the installment plan is still strangulation.

Vague as the Administration's plans are, pending the round of public hearings, advisory-group meetings, and think-tank deliberations, we know there is nothing vague about the wishes of organized labor, the special-interest group that is loudest in its demands for a heavily federalized NHI program.

It seems ironic to me that labor is greatly vexed about the extent to which the cost of employee group coverage cuts into money available for negotiated wages and fringe benefits but is apparently nonchalant about the extent to which its pet Kennedy-Corman bill would cut into the income of the general public including, of course, its own members.

The Congressional Budget Office has estimated that a NHI program financed wholly by taxes, as provided in that bill, could raise federal health spending by $168 to $200 billion by fiscal 1982. That extra tax bite could average almost $1,000 for every man, woman, and child. Outrageous as its fiscal thinking is, organized labor will have to be considered and placated when the Administration develops its NHI proposal. So let us all be thoroughly prepared for the prospect that the current cloudiness in the NHI sky may turn into storm clouds.

There is only one way to be prepared, my friends: by pushing as hard as we can and as concertedly as we can for our own Comprehensive Health Care Insurance bill. Only through this measure can we meet the challenge I set forth earlier: the challenge of simultaneously doing justice to the public interest and our professional



Dr. Budd addresses the AMA House of Delegates.

rights. Only through this measure can every American, regardless of financial means, have open doors to the full benefits of the American health-care system without running into bureaucratic walls.

In offering this bill and gathering Congressional support for it, we of the AMA are not sticking our necks out. On the contrary, it is a reasonable and responsible way to save them. At the same time, we must be reasonable and responsible on the issue of rising medical costs which is playing into the political hands of the most belligerent proponents of federalized NHI.

Let us recall that HEW Secretary Califano, at our San Francisco convention, warned that the proposed price ceilings on hospitals are "merely a stopgap measure." For the long run, he added, the system of care must be more effectively organized. And in the next breath, he called for a "fair and effective" system of National Health Insurance. So it follows that an Administration-sponsored NHI plan, more than being just an insurance mechanism, may be a tight framework for the delivery of care, with rigid cost control as a principal public allurement.

It is important that we disseminate the unavoidable reasons for rising cost, ranging from heightened technology to greater public demand for that technology, from general inflation to mounting payrolls in a labor-intensive industry, notably hospitals, plus long-term care for the millions of people whom we have enabled to live longer. But it is also urgent that we physicians, in cooperation with hospitals and insurers, pursue workable means of cost containment.

It is not my task to assess the thoughtful approaches recommended by our National Commission on the Cost of Medical Care. However, I feel that as your President I can urge such steps as these:

* Innovations in cost effectiveness through reimbursement formulas, for example.
* Optional forms of family and employee group coverage, so that less inclusive, less expensive forms are available.
* "Truth in Insurance" programs to clarify just what the client receives from his policy.
* And voluntary local initiative against needless duplication of facilities and equipment.

Our comprehensive Health Care Insurance bill embodies a logical mix of cost restraints including coinsurance, as a curb on gratuitous demand for services, varied formulas for hospital reimbursement, emphasis on home care when feasible—usual, customary, and reasonable fees for medical services and, far from least, an avoidance of the dead financial weight that bureaucracy would impose.

HEW Secretary Califano himself was quoted by the Associated Press as estimating Medicaid waste at more than $2 billion a year with errors by government agencies accounting for 62 percent of the losses ascribed to ineligible recipients. We must ask the public if it wants such waste and error multiplied on a National Health Service scale. We must ask the public if fiscal wildness of the National Health Service type is justified by the present state of medical care.

As a buildup for further federal inroads, wild assertions have been flung at the care our patients receive. We have been machine-gunned with exaggerations of Medicaid-Medicare overpayments, which HEW had to retract and exaggerations of unnecessary surgery, when the evidence shows that physicians and their wives have a higher rate of surgical procedures than the public at large. If doctors are needlessly operating on each other, that would be a pretty sorry form of log-rolling!

In the face of this orchestrated propaganda, how do Americans themselves feel about the care they receive? To quote the Gallup survey, "Respondents expressed a high degree of satisfaction with their doctors."

Let me pose some further questions and supply answers recently given by the Robert Wood Johnson Foundation. Are Americans, especially the poor, substantially denied access to health services? The answer is that physician visits per person rose 19 percent between 1969 and 1975 and visits by low-income people averages six in 1975, compared with a national average of five.

Is infant mortality high? From 1960 to 1975 it fell by 38 percent from 26 deaths per 1,000 live births to an all-time low of 16.

What about adult death rates? Generally they have dropped notably in such areas as coronary heart disease, strokes, diabetes, and peptic ulcers.

As the Johnson Foundation spokesmen commented, "things have changed, and changed for the better. In our pluralistic, sometimes groping American way, many groups, institutions, and individuals have participated in strengthening medical care services. The data suggest that our American system does work, and perhaps better than we are sometimes wont to recognize."

The reality of achievement helps point up what a tremendous teaching job you and I have to do. But to do that job effectively, you and I have to come to grips with our attitude toward our individual selves and toward each other. We must stop apologizing for ourselves and for this great federation. The concerted effort to throw us and the AMA off balance is all the more reason to keep our balance. To sustain our equilibrium, we must have unity within this federation and in behalf of this federation.

I know that AMA officers over and over again have pleaded for unity. But no matter how weary that word may sound, it calls for continued vigor. No individual physician regardless of how big he may feel can stand up to Big Government. No splinter group can be anything more than a splinter at a time when we must be a forest of strength.

I have argued the case of moderation because it alone can bring a sense of proportion to the issues that hit us from all sides. But through this House of Medicine, our moderation can be as formidable as all the issues and all the winds that blow.

The Ohio State Medical Association Continuing Education Programs

Editor's Note: *The following are Category I courses offered in Ohio. Items for this listing come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in dates, places, or time occur too late to be corrected before publication. Physicians interested in a course are urged to contact the sponsoring organization to confirm the information listed. Sponsoring organizations may list Category I courses by contacting the OSMA Department of Continuing Medical Education or The Journal. Notification 90 days prior to the course would be appreciated. Due to space limitations, announcements may be published only once.* **See previous issues of The Journal for additional courses.**—*L.A.J.*

January 1978

TENTH ANNUAL INFECTIOUS DISEASES CONFERENCE: January 12; University of Cincinnati College of Medicine, Cincinnati; 6 credit hours; fee: $40, $25 residents; contact: Office of CONMED, Dean's Suite, E251, University of Cincinnati College of Medicine, Cincinnati 45267, phone: 513/872-5486.

CHRONIC COMPLICATIONS OF DIABETES: January 18; Mount Carmel Medical Center Hospital, Columbus; 5 credit hours; fee: $3, students and residents- no charge; contact Mount Carmel Medical Center, Central Office of Education, 793 West State Street, Columbus 43222, phone: 614/225-5178.

February 1978

SURGICAL MANAGEMENT OF ENDOCRINE DISORDERS—PART I: January 19; St. Elizabeth Hospital Medical Center, Youngstown; 4 credit hours; contact: Rashid A. Abdu, M.D., Director of Education, Belmont and Park Avenues, Youngstown 45501, phone: 216/746-7211, ext. 202.

THIRD CLEVELAND SYMPOSIUM ON INFECTIOUS DISEASES AND ANTIMICROBIAL DRUGS: February 8-9; The Cleveland Clinic Foundation, Cleveland; 12 credit hours; fee: $100, $50 physicians-in-training; contact: Penn G. Skillern, M.D., Center for CME, The Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

CONGENITAL HEART DISEASE IN ADULTS (James Kilman, M.D., Professor and Director of Division of Thoracic Surgery at OSU- Speaker): February 9; Community Medcenter Hospital, Marion; 1 credit hour; contact: Robert R. Tracht, Administrator, 1050 Delaware Avenue, Marion 43302, phone: 614/383-6301, ex. 292.

INS AND OUTS WITH GASTROENTEROLOGY: February 10-12; Hueston Woods Lodge, College Corner; sponsor: Ohio Academy of Family Physicians; cosponsor: Indiana Academy of Family Physicians; 8 credit hours; fee: $45 AAFP members, $25 FP residents, $55 non-members; contact: Mrs. Florence I. Landis, Executive Director, Ohio Academy of Family Physicians, 4075 North High Street, Columbus 43214, phone: 614/267-7867.

WORKSHOP IN SOFT TISSUE SURGERY: February 10-12; Park Plaza Hotel, Cleveland; 15 credit hours; sponsor: Cleveland Clinic Educational Foundation; fee: $200, $150 physicians-in-training; contact: Penn G. Skillern, M.D., Center for CME, The Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

SELECTED TOPICS IN GASTROENTEROLOGY AND HEPATOLOGY: February 15, 8:30 AM-5 PM; Lutheran Medical Center, Cleveland; 6 credit hours; fee: $50; contact: Lutheran Medical Center, Office for Continuing Medical Education, 2609 Franklin Blvd., Cleveland 44113, phone: 216/696-4300, ext. 329.

G.I. VASCULAR OCCLUSIVE DISEASE: February 16; St. Elizabeth Hospital Medical Center, Youngstown; 4 credit hours; contact: Rashid A. Abdu, M.D., Director of Education, Belmont and Park Avenues, Youngstown 45501, phone: 216/746-7211, ext. 202.

NEUROLOGY: February 22; Middletown Hospital, Middletown; 3 credit hours; fee: $35; contact: Office of CONMED, 231 Bethesda Avenue, Cincinnati 45267, phone: 513/872-5486.

March 1978

SURGICAL IMMUNOLOGY: March 2; St. Elizabeth Hospital Medical Center, Youngstown; 4 credit hours; contact: Rashid A. Abdu, M.D., Director of Education, Belmont and Park Avenues, Youngstown 45501, phone: 216/746-7211, ext. 202.

CRITICAL REVIEW OF SURGERY OF THE COLON AND RECTUM: March 3-4; Cleveland Clinic Foundation, Cleveland; 12 credit hours; fee: $150, $75 physicians-in-training; contact: Penn G. Skillern, M.D., Center for CME, The Cleveland Clinic Educational Foundation, Cleveland 44106, phone: 216/444-5696.

ADVANCES IN UROLOGY: March 9-10; Cleveland Clinic Foundation, Cleveland; 12 credit hours; fee: $125, $65 physicians-in-training; contact: Penn G. Skillern, M.D., Center for CME, The Cleveland Clinic Educational Foundation, Cleveland 44106, phone: 216/444-5696.

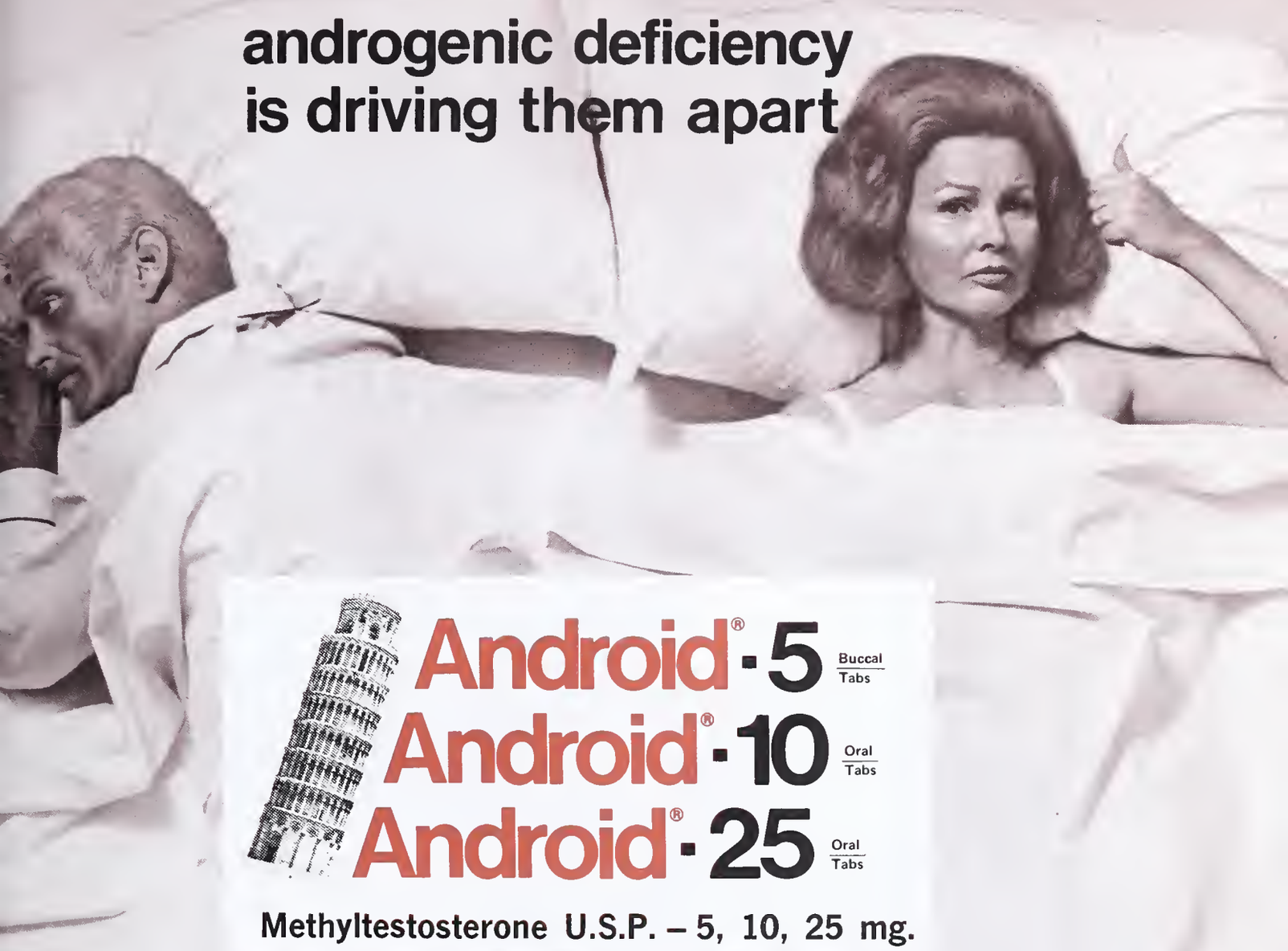
REFRESHER SEMINAR IN PEDIATRICS FOR PEDIATRICIANS AND FAMILY PHYSICIANS: March 15-16; Cleveland Clinic Foundation, Cleveland; 12 credit hours; fee: $90, $45 physicians-in-training; contact: Penn G. Skillern, M.D., Center for CME, The Cleveland Clinic Educational Foundation, Cleveland 44106, phone: 216/444-5696.

SURGICAL PHARMACOLOGY: March 16; St. Elizabeth Hospital Medical Center, Youngstown; 4 credit hours; contact: Rashid A. Abdu, M.D., Director of Education, Belmont and Park Avenues, Youngstown 45501, phone: 216/746-7211, ext. 202.

UPPER GASTROINTESTINAL ENDOSCOPY-DIAGNOSTIC AND THERAPEUTIC TECHNIQUES: March 17-18; Cleveland Clinic Foundation, Cleveland; 12 credit hours; fee: $150, $75 physicians-in-training; contact: Penn G. Skillern, M.D., Center for CME, The Cleveland Clinic Educational Foundation, Cleveland 44106, phone: 216/444-5696.

When **impotence** *due to*

androgenic deficiency is driving them apart



Android®-5 Buccal Tabs

Android®-10 Oral Tabs

Android®-25 Oral Tabs

Methyltestosterone U.S.P. – 5, 10, 25 mg.

Additional Indications:
REPLACEMENT THERAPY. When Androgen Deficiency is cause of:

- Male Climacteric
- Eunuchoidism, Eunuchism
- Post-Puberal Cryptorchidism

New Double-Blind Study ANDROID-25 vs. Placebo*

*R. B. Greenblatt, M.D.; R. Witherington, M.D.,; I. B. Sipahioglu, M.D.; Hormones for Improved Sexuality in the Male and Female Climacteric. **Drug Therapy,** Sept. 1976.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** Robert **B. Greenblatt, M.D.,** and **D. H. Perez, M.D.:** "The Menopausal Syndrome," *Problems of Libido in the Elderly,* pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

BROWN **THE BROWN PHARMACEUTICAL CO., INC.** 2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

Write for Reprints and Samples.

Clinical experience & continuing confidence

KAON® ELIXIR was introduced in **1954,** followed by KAON® TABLETS in **1963.** Decades of clinical experience indicate acceptability, effectiveness, and safety in the majority of patients; should abdominal pain occur, therapy should be discontinued. Both have been taken by patient after patient, day after day, year after year, to correct potassium deficiencies. Both have consistently demonstrated their value when diet alone is inadequate for potassium replacement.

Kaon® Elixir
(potassium gluconate)

Kaon® Tabs
(potassium gluconate)

BRIEF SUMMARY
Kaon Tablets/Kaon Elixir

KAON® (potassium gluconate) TABLETS

Description: Each sugar-coated tablet supplies 5 mEq. of elemental potassium (as potassium gluconate 1.17 Gm.). Kaon Tablets are sugar coated, not enteric coated, which favors dissolution in the stomach and absorption before reaching the small intestine where the lesions with enteric potassium chloride have occurred. The sugar coating merely adds to palatability and ease of swallowing, not to delay absorption as does the enteric coating.
Indications: Oral potassium therapy for the prevention and treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. It may be used in the treatment of cardiac arrhythmias due to digitalis intoxication.
Contraindications: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause.
Warning: There have been several reports, published and unpublished, concerning nonspecific small-bowel lesions consisting of stenosis, with or without ulceration, associated with the administration of enteric-coated potassium tablets alone or when they are used with nonenteric-coated thiazides or certain other oral diuretics. These small-bowel lesions have caused obstruction, hemorrhage and perforation. Surgery was frequently required and deaths have occurred. Available information tends to implicate enteric-coated potassium salts, although lesions of this type also occur spontaneously. Therefore, coated potassium-containing formulations should be administered only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Coated potassium tablets should be used only when adequate dietary supplementation is not practical.
Precautions: In response to a rise in the concentration of body potassium, renal excretion of the ion is increased. With normal kidney function, it is difficult, therefore, to produce potassium intoxication by oral administration. However, potassium supplements must be administered with caution, since the amount of the deficiency or daily dosage is not accurately known. Frequent checks of the clinical status of the patient, and periodic ECG and/or serum potassium levels should be made. High serum concentra-

Time is the test of all things



tions of potassium ion may cause death through cardiac depression, arrhythmias or arrest. This drug should be used with caution in the presence of cardiac disease.

In hypokalemic states, especially in patients on a salt-free diet, hypochloremic alkalosis is a possibility that may require chloride as well as potassium supplementation. In these circumstances, Kaon (potassium gluconate) should be supplemented with chloride. Ammonium chloride is an excellent source of chloride ion (18.7 mEq. per Gram), but it should not be used in patients with hepatic cirrhosis where ammonium salts are contraindicated. Other sources for chloride are sodium chloride and Diluted Hydrochloric Acid, U.S.P.

It should also be kept in mind that ammonium cycle cation exchange resin, sometimes used to treat hyperkalemia, should not be administered to patients with hepatic cirrhosis.

Adverse Reactions: Nausea, vomiting, diarrhea and abdominal discomfort have been reported. The symptoms and signs of potassium intoxication include paresthesias of the extremities, flaccid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, fall in blood pressure, cardiac arrhythmias and heart block. Hyperkalemia may exhibit the following electrocardiographic abnormalities: disappearance of the P wave, widening and slurring of QRS complex, changes of the S-T segment, tall peaked T waves, etc.

Overdosage: Potassium intoxication may result from overdosage of potassium or from therapeutic dosage in conditions stated under "Contraindications." Hyperkalemia, when detected, must be treated immediately because lethal levels can be reached in a few hours.

KAON® (potassium gluconate) ELIXIR

Description: Each 15 ml. (tablespoonful) supplies 20 mEq. of elemental potassium (as potassium gluconate, 4.68 Gm.) with saccharin and aromatics. Alcohol 5%.

Indications: See Kaon Tablets.

Precautions: See Kaon Tablets.

In hypochloremic alkalosis, potassium replacement with potassium chloride (e.g., Kaochlor® 10% Liquid) may be more advantageous than with other potassium salts.

Adverse Reactions: See Kaon Tablets.

Overdosage: See Kaon Tablets.

WARREN-TEED
PHARMACEUTICALS INCORPORATED
COLUMBUS, OHIO 43215



Legislative Update

the federal scene

(Courtesy the OSMA Department of Federal Legislation and the AMA Washington Office)

Physicians' Incomes and the Cost of Health Care

What about the true cost of health care and the true nature of physicians' incomes? Last month, this column carried the American Medical Association's factual findings on health-care costs. This month's column continues the discussion the AMA prepared regarding the facts surrounding physicians' incomes, including comparison with other segments of American society.

A news release from HEW says the "typical" physician worked 58 hours a week in 1975 and earned $53,600 after business expenses. Quicker than you can say "rip-off," doctors, the announcement was broadcast widely and turned into headlines. There isn't much wrong with HEW's propaganda in this case, except that it tells only part of the story. It mentioned only some of the statistics the federal government assembled in 1975 on work and its rewards.

For instance, HEW didn't mention that if a physician worked 58 hours a week, he was working 61 percent longer hours than the average American. According to the *Statistical Abstract of the U.S.,* the average workweek in 1975 was 36.1 hours. The typical physician's income would work out to about $33,400 if he had worked the average 36.1-hour week (or $36,900, if based on a 40-hour week).

A comparison with federal employees and career civil service employees might be of interest. A $53,600 income would be the earnings (not including fringe benefits) of a person at the presidential or secretarial appointment level, the lowest grade of which receives a salary of $47,500. A congressman or senator earns $57,500; Secretary Califano makes $66,000.

Physicians' net earnings, of course, usually include whatever amounts the doctor must pay for his own "fringe" benefits. Employed workers usually have these benefits paid, at least in part, by their employer.

"Comparing (physician) incomes in urban and rural areas," the HEW release says, "there is an overall difference between the two of $6,300, the financial advantage resting with urban practitioners." (11.8 percent.)

What HEW didn't say is that federal statistics show that living costs in metropolitan areas are 13.3 percent greater, on average, than in nonmetropolitan areas. The difference can be as great as 67.1 percent, according to the U.S. Bureau of Labor Statistics.

There is one more statistic HEW didn't mention. According to the Associated Press, HEW spent about $400,000 to glean these facts about physicians' earnings and hours. According to statistics in the April 1977 *Social Security Bulletin,* that amount would have paid the doctor bills of 3,780 Americans in 1975.

Will national health insurance control costs? There is sobering reason to distrust the argument that it will. The February issue of *Fortune* maintains:

> Far from curing the inflation national health insurance could well have the unpleasant result of aggravating the problem. The combination of private and government insurance that now covers 92 per cent of the population has itself been a major inflationary force.

Those who look to a "free" but frighteningly expensive Kennedy-style bill to cool inflation in medical costs, as the Senator's Committee for National Health Insurance does, are really saying that the way to extinguish a fire on a tank farm is to spray the flames with more oil.

Not that physicians are oblivious to the need for cost restraint. Organized medicine is: (1) working with hospitals to moderate costs; (2) making physicians aware of costs of tests and procedures; and (3) cooperating with private and public health insurance programs to monitor costs of various procedures, length of hospital stays, etc.

But modern, high-quality medical care necessarily involves high costs. The physician's personal role in costs is grossly exaggerated, almost to exclusion of impersonal ones— such as technical advances, longevity-related sickness, greater demand for care, inflation in general, exorbitant malpractice insurance premiums, and costs of government regulations and bureaucracy.

Reckless cost-cutting inevitably results in rationing of care given patients, rationing of quality of— or access to — care, or both. Under the British National Health Service, 600,000 patients have been waiting six months to four years for elective surgery. Many British hospitals are outmoded, far below the U.S. standards; many date to the last century.

The AMA has a blue-ribbon National Commission on the Cost of Medical Care, representing many walks of life. It is reviewing and evaluating information to place cost problems in correct perspective— so suggested remedies can be equally correct. A final report is targeted for this January.

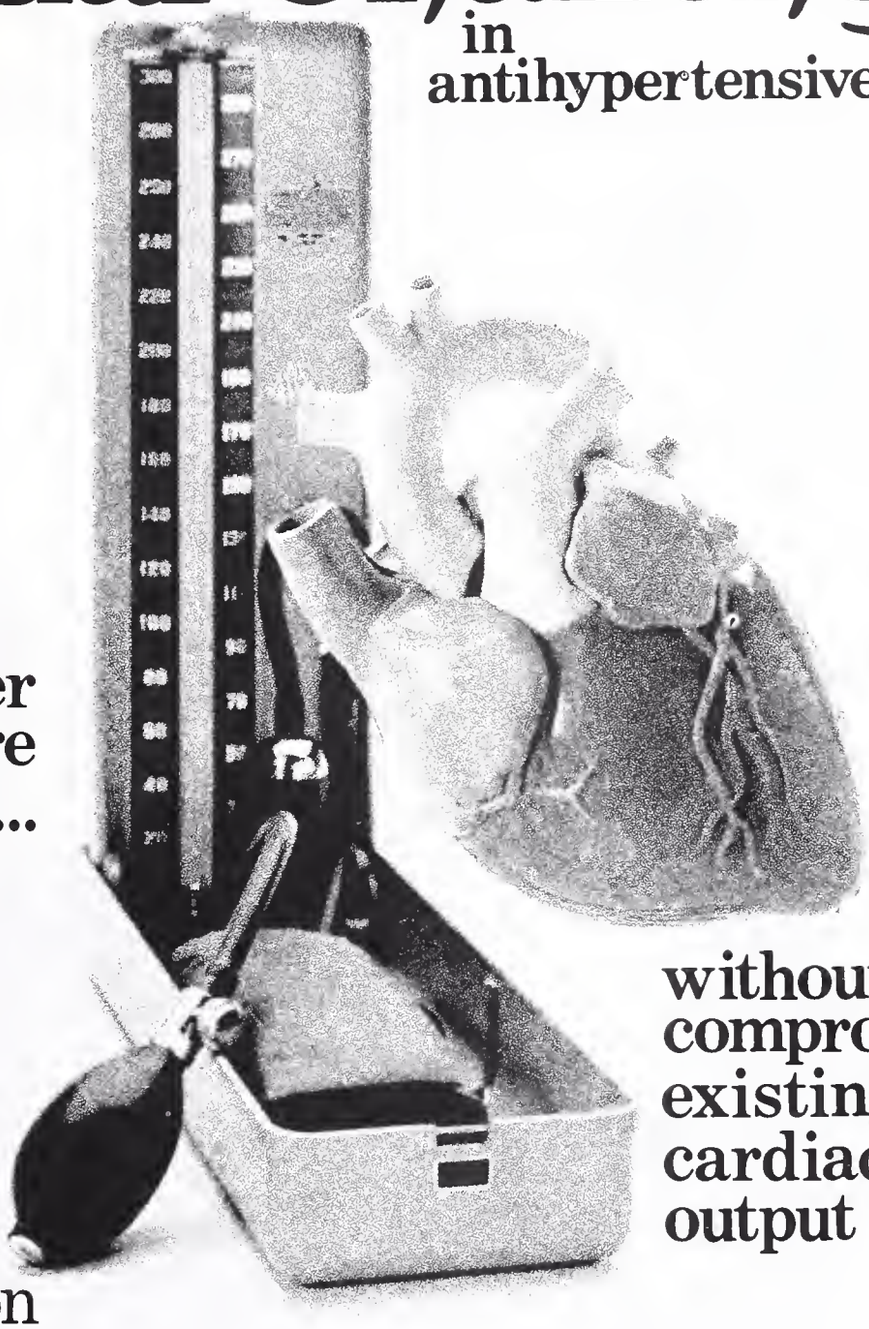
Three years ago, in its *Report on Physician-Hospital Relations, 1974* the AMA emphasized that physicians should at least be **aware** of total costs and use less costly procedures **so long as it is medically proper to do so.**

Thus, the AMA report recommends appropriate remedies, such as: (1) lists of all hospital rates and charges be routinely provided to staff physicians for their consideration; (2) medical staffs consult on a regular basis with governing boards and administrators about rates and charges and cooperate in feasible programs to lower costs; and (3) physicians order only those tests and procedures necessary for effective diagnosis and treatment.

In the last analysis, however, **each** physician gives the health and life of each patient priority over costs. Do the American people **really** wish it otherwise?

A Dual Challenge

in antihypertensive therapy



to lower blood pressure effectively...

without compromising existing cardiac output

in hypertension

TABLETS: 250 mg, 500 mg, and 125 mg

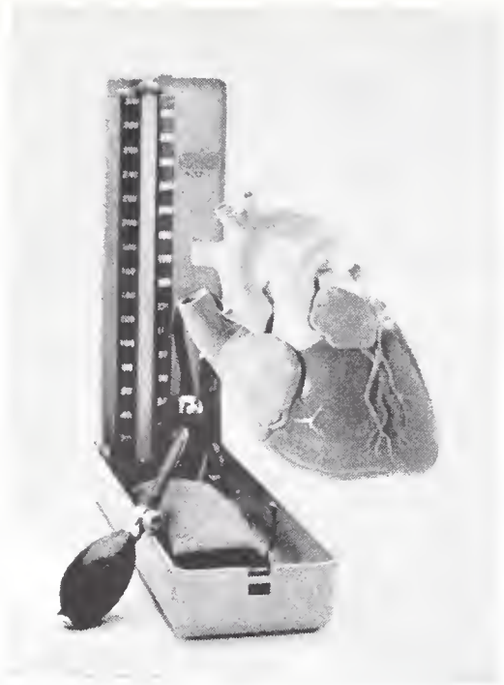
ALDOMET® (METHYLDOPA | MSD)

helps lower blood pressure effectively... usually with no direct effect on cardiac function–cardiac output is usually maintained

ALDOMET is contraindicated in active hepatic disease, hypersensitivity to the drug, and if previous methyldopa therapy has been associated with liver disorders.
It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

For a brief summary of prescribing information, please see following page.

MSD
MERCK SHARP & DOHME



in hypertension

ALDOMET®

(METHYLDOPA|MSD)

helps lower blood pressure effectively... usually with no direct effect on cardiac function– cardiac output is usually maintained

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis; if previous methyldopa therapy has been associated with liver disorders (see Warnings); hypersensitivity.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, occasionally with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reactions or unusual manifestations of drug idiosyncrasy.

Pregnancy and Nursing: Use of any drug in women who are or may become pregnant or intend to nurse requires that anticipated benefits be weighed against possible risks; possibility of fetal injury or injury to a nursing infant cannot be excluded. Methyldopa crosses the placental barrier, appears in cord blood, and appears in breast milk.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of: urinary uric acid by the phosphotungstate method, serum creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has recurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: *Central nervous system:* Sedation, headache, asthenia or weakness, usually early and transient; dizziness, lightheadedness, symptoms of cerebrovascular insufficiency, paresthesias, parkinsonism, Bell's palsy, decreased mental acuity, involuntary choreoathetotic movements; psychic disturbances, including nightmares and reversible mild psychoses or depression.

Cardiovascular: Bradycardia, aggravation of angina pectoris. Orthostatic hypotension (decrease daily dosage). Edema (and weight gain) usually relieved by use of a diuretic. (Discontinue methyldopa if edema progresses or signs of heart failure appear.)

Gastrointestinal: Nausea, vomiting, distention, constipation, flatus, diarrhea, mild dryness of mouth, sore or "black" tongue, pancreatitis, sialadenitis.

Hepatic: Abnormal liver function tests, jaundice, liver disorders.

Hematologic: Positive Coombs test, hemolytic anemia. Leukopenia, granulocytopenia, thrombocytopenia. Positive tests for antinuclear antibody, LE cells, and rheumatoid factor.

Allergic: Drug-related fever, lupus-like syndrome, myocarditis.

Other: Nasal stuffiness, rise in BUN, breast enlargement, gynecomastia, lactation, impotence, decreased libido, dermatologic reactions including eczema and lichenoid eruptions, mild arthralgia, myalgia.

Note: Initial adult dosage should be limited to 500 mg daily when given with antihypertensives other than thiazides. Tolerance may occur, usually between second and third months of therapy; increased dosage or adding a diuretic frequently restores effective control. Patients with impaired renal function may respond to smaller doses. Syncope in older patients may be related to increased sensitivity and advanced arteriosclerotic vascular disease; this may be avoided by lower doses.

How Supplied: Tablets, containing 125 mg methyldopa each, in bottles of 100; Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 500.

For more detailed information, consult your MSD representative or see full prescribing information.

Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

J6AM07R1(709)

MSD MERCK SHARP & DOHME

THE OHIO STATE Medical Association Clinical and Scientific

Six Hundred Ninety Total Hip Replacements

A Comparative Study

Thomas H. Mallory, M.D.
Thomas L. Meyer, Jr., M.D.
Jaren D. Bombach, M.D.

Between 1971 and 1975, in a community teaching hospital, 690 total hip replacements were performed. A rigid preoperative and postoperative protocol was followed by all participating orthopedic surgeons. Satisfactory results were obtained, with results comparable to statistics from large specialty centers involved in similar surgical procedures. The complication rate, as related to surgery was 8 percent, and the associated medical complication rate was 25 percent.

TOTAL HIP ARTHROPLASTY was proposed by Wills in 1938. It was not until the early 1960s that the technique was perfected by Charnley, McKee, Ring, and Mueller.[1-4] The initial experience with total hip replacement occurred in large medical centers which gave the procedure the aura of specialty orientation. Patterson and Brown reviewed 403 McKee-Farrar total hip replacement arthroplasties performed by a group of orthopedic surgeons who were not specially trained in the technique. The surgical procedures were performed in several large general hospitals under standard, orthopedic operating room conditions.[5] It was concluded that the overall results of total hip replacement were impressive, but a large number of technical and mechanical failures occurred which led to the belief that this type of surgery should be done in a restricted context. The Patterson and Brown review left a question in the minds of many as to whether or not total hip replacement can be done effectively in a community hospital setting by orthopedic surgeons with a general background. Does such an environment produce an excessive number of complications, and is there an associated decrease in the quality of results? The purpose of this study is to evaluate 690 total hip replacements performed in a community teaching hospital* with parallel comparisons of results emanating from large specialty centers.

Method

A protocol was established prior to the first total replacement performed in March 1971. This protocol included a restricted area for the care of total-joint-replacement patients. The preoperative patient preparation included medical consultation, the use of paraoperative antibiotics, and appropriate cleansing techniques for the

Dr. Mallory, Columbus, Chief of Orthopedics, St. Ann's Hospital; Active Member, Department of Orthopedics, Mount Carmel Medical Center; Courtesy Staff, Children's and Riverside Hospitals; and Clinical Instructor, Department of Orthopedics, The Ohio State University College of Medicine.

Dr. Meyer, Columbus, Chairman, Department of Orthopedics, and Chief, Orthopedic Residency Program, Mount Carmel Medical Center; Attending Staff, The Ohio State University Health Center; and Clinical Assistant Professor, Department of Orthopedics, The Ohio State University College of Medicine.

Dr. Bombach, Columbus, Resident in Orthopedics, Mount Carmel Medical Center.

Submitted June 23, 1977.

*Mount Carmel Medical Center, Columbus, Ohio (600 beds). By memorandum of agreement, this hospital participates with the College of Medicine at The Ohio State University in various teaching programs.

operative site. Operating room restrictions included a clean air unit as well as the use of appropriate hoods and gowns by the surgical team and the restriction of operating room traffic. Postoperative protocol included the continuation of paraoperative antibiotics, the use of anticoagulants, and a strict rehabilitation program.

Method of Evaluation

Fifteen orthopedic surgeons performed the 690 total replacements evaluated. The method of chart review for this study included the use of a punch-card analysis system. Individual surgeons were contacted in regard to their patient's condition when complications were encountered, and subsequent analysis of the results were evaluated. The follow-up for this study ranged from one to four years.

Patient Selection

The patient population consisted of individuals in the fifth and sixth decades of life, the average age being 63 years. However, the youngest patient was 23 years old and the oldest was 92. The selection of patients for total hip replacement was based on disabling hip pain, affected walking status, and restricted functions of daily living.

Primary hip surgery was performed in 536 cases (77.6 percent). Osteoarthritis occurred in 358 cases (66 percent); rheumatoid arthritis in 68 cases (12.5 percent); traumatic arthritis in five cases (0.9 percent); Legg-Calve-Perthes disease constituted ten cases (1.8 percent); and secondary degenerative arthritis resulting from congenital dysplastic hip disease occurred in 22 patients (4 percent). Hip fractures with subsequent complications contributed 71 cases (13 percent). The sequelae of fractures of the acetabulum resulted in two total hip replacements (0.3 percent). There were 154 cases (28.3 percent) in which previous hip surgery had occurred, including previous osteotomies, cup arthroplasties, endoprostheses, failed arthrodeses, and failed nonacrylic total hip replacement. Of the 690 total hip replacements performed, 483 were unilateral (70 percent); 207 were bilateral (28 percent).

Surgical Data

The surgical procedure included 662 cases (95.9 percent) performed in the lateral position; 28 cases (4.1 percent) were performed in the supine position. The anterior incision was used in four cases (0.6 percent); the lateral incision was used in 679 cases (98.4 percent); and the posterior approach was utilized in seven cases (about 1 percent).

The Charnley-Mueller™ prosthesis was used in 342 cases (49.5 percent), the Aufranc-Turner prosthesis in 188 cases (27.2 percent), and the Charnley prosthesis in 49 cases (7.1 percent). Other prostheses used included the Trapezoid-28,™ Bechtol,™ and Buchholz.™

The average anesthesia time for total hip replacement was 2.8 hours. Operating time averaged two hours, however, 191 cases (27.6 percent) were completed within one hour. Three hundred and fifty-six cases (57.7 percent) were completed within two hours; 167 cases (25.1 percent) were completed within three hours; and 45 cases (6.5 percent) took more than four hours. The average postoperative blood replacement was two units. There was a concomitant, postoperative hemaglobin drop of 2 grams. Autotransfusion was used in 63 of the 690 cases. Two grams of cephalothin was given the morning of surgery and continued for five to seven days at the dosage of 2 grams every six hours intravenously. When penicillin allergies were encountered, clindamycin was used at the dosage of 60 mg, intravenously, every eight hours for two to five days. Random anticoagulation agents used were: aspirin, Coumadin,® dextran, and heparin. The selection of the anticoagulant regime was at the discretion of the participating surgeon.

Following the surgery, the operated extremity was immobilized in Buck's traction or with the use of an abduction pillow. The patients were confined to bed rest for five days. The average hospital stay was 23 days; the average postoperative stay 18 days. The patients were discharged when they were walking well with crutches or canes. They were evaluated four to six weeks later, following which they were allowed to walk without aids providing they had no limp. The patients then were evaluated at yearly intervals.

Medical Complications

Cardiopulmonary.— Cardiopulmonary complications occurred in 46 of the 690 patients (6.7 percent) undergoing total hip replacement. This included congestive heart failure, cardiac arrhythmias, myocardial infarctions, cardiac arrest, and angina pectoris. Pulmonary complications included atelectasis, spontaneous pneumothorax, and pneumonia.

Thrombophlebitis and Pulmonary Embolus.— Twenty-seven patients (3.0 percent) in this series of 690 total hip replacements experienced a documented pulmonary embolus as confirmed by altered blood gas studies, positive lung scans, and changes shown on x-ray films. Two pulmonary emboli caused fatal complications (0.3 percent) and were documented by autopsy studies. There were 35 cases (5.1 percent) showing evidence of clinical thrombophlebitis as evidenced by a swollen extremity and tender calf muscles. All patients in this review were given anticoagulants — aspirin, Coumadin,® dextran, or mini-dose heparin. Of the 27 documented cases of pulmonary emboli, 18 patients had anticoagulant therapy with aspirin, three with Coumadin,® and six with dextran. The other anticoagulant, mini-dose heparin, was used in 40 patients. There were no documented pulmonary emboli in the heparin group; however, 50 percent of the patients experienced bleeding complications. Of the 454 cases in which aspirin was the anticoagulant, 18 (4.1 percent) developed pulmonary emboli. Of the 75 patients treated with Coumadin,® three developed pulmonary emboli (4 percent).

For the 161 patients given dextran, six of them had documented emboli, a 4-percent incidence.

Gastrointestinal.— Significant gastrointestinal problems were noted in 22 cases (3.2 percent). These included postoperative ileus and cholecystitis. Cholecystectomy was necessary in two cases.

Renal.— Acute urinary retention occurred in 25 cases (3.6 percent) following total hip replacement. An additional four cases of renal complications included acute renal failure, renal lithiasis, cystitis, and pyelonephritis.

Pyrexia.— One hundred and four patients (15.1 percent) in this series of 690 total hip replacements demonstrated a temperature greater than 38 C (101 F), which occurred within the first four days following surgery. On many occasions, the temperature elevation was thought to be due to atelectasis or other pulmonary causes.

Mortality.— Six patients (0.9 percent) died in this series. The cause of death was documented in three patients and included pulmonary embolus and cardiac arrest. Cause of death in the other three cases was not documented with autopsy studies.

Orthopedic Complications

Dislocations.— Dislocation of the prosthesis occurred in 15 patients (2 percent). Fourteen of the 15 dislocations occurred within the first two weeks following total hip replacement. One dislocation occurred three months after the initial surgery. Of the 15 dislocations, there were associated incidents of fracture of the femur in five cases (33 percent). Also, five patients had undergone previous surgery. Ten dislocations were managed by closed reduction (66 percent); five patients required open reduction.



FIG. 1. Increased abduction of cup leading to instability of prosthesis and subsequent dislocation.



FIG. 2. Periosteal elevation and radiolucency about stem of femoral component indicating infection.

In one patient, three dislocations occurred before stability was accomplished (Fig. 1).

Infection.— Deep infection, as defined by Wilson, et al, was noted in 9 of the 690 cases reviewed (1.3 percent).[6] Four infections (44 percent) appeared within the first three months following total hip replacement; five (56 percent) appeared at a later date. Of the nine patients in



FIG. 3. Radiolucency about stem of femoral component indicating loosening of bone cement.

which infection occurred, four had previous surgery. Types of bacteria included seven gram-negative organisms, primarily Pseudomonas and Proteus. In two patients, infections were caused by gram-positive cocci (one Staphylococcus and one Streptococcus). All patients were treated with debridement followed by either closed-tube irrigation or open packing of the wound. Four patients (44 percent) eventually had extirpation of their prostheses and were left with a girdlestone arthroplasty. The five remaining cases of infection appeared to be in a quiescent state (Figs. 2 and 3).

Fractured Femur.— There was a 1-percent incidence of fracture of the femur as noted in seven cases. Four of the seven cases (57.1 percent) had previous hip surgery. The fractures occurred in association with removal of bone cement, removal of internal fixation device, associated osteoporosis, and/or poor visualization secondary to surgical exposure (Figs. 4 and 5).



FIG. 5. Penetration of femoral shaft with femoral component.

Discussion

The results of total hip replacement performed in a community hospital were compared with previous statistics published from large medical centers performing similar surgery.[7-9] The surgery performed in this community teaching hospital setting was regulated by a disciplined protocol. Selected parameters of medical and orthopedic complications were considered and appropriate comparisons made.

The results of the parameters compared for the performance of the surgery were similar in all series regarding blood loss, surgical time, and anesthesia time. (See Table). In fact, in the community hospital, where hypotensive anesthesia was used routinely, there was a shorter operative time and less blood loss noted.[10] Selection of the prosthesis was at the preference of the participating surgeon, the large-head system being preferred.



FIG. 4. Stress fracture beneath tip of femoral component resulting from inadequate fixation.

Complications related to the arthroplasty itself were interesting. A 2-percent dislocation rate occurred in the community hospital setting, with a similar rate occurring in the large center survey. Fractures associated with the arthroplasty were at a comparative level of approximately 1 percent. Infections varied with the length of the follow-up. In one major hip center, infection rate was recorded as high as 6.6 percent, but the follow-up was approximately ten years.[7] Other large centers recorded infection rates ranging from 1 to 2 percent. The community hospital had a comparative level of 1.3 percent. The overall orthopedic complications related to the arthroplasty itself performed in the community hospital setting averaged 8 percent, as compared to approximately 6 percent in the large specialty environment. Therefore, there was little difference in the incidence of complications associated with total hip replacements performed in the series compared.

Medical complications related to the arthroplasty revealed that cardiopulmonary complications were higher in the community hospital. The incidence of pulmonary embolus, urogenital, renal, and gastrointestinal complica-

Comparative Complications of Total Hip Replacement

Complications	Charnley Center for Hip Surgery %	Mayo Clinic %	University of California %	Mount Carmel %
		Orthopedic Complications Related to Surgery		
Dislocation	1.5	3.0	3.0	2.0
Loose prosthesis	1.0	4.2	1.2	1.0
Fractured femur	0.02	?	1.0	1.0
Infection	3.8	1.2	1.5	1.3
		Complications Related to Medical Aspects		
Cardiac	?	1.7	1.3	4.0
Pulmonary	?	1.7	?	2.7
Thrombophlebitis	5.5	3.4	5.0	5.0
Pulmonary embolus	3.2	2.2	3.0	4.0
Urogenital	?	11.9	2.0	3.6
Gastrointestinal	?	2.4	0.5	3.2
Mortality	2.1	0.4	0.8	1.0

tions were at similar rates. The morbidity associated with the operation also was at a comparative level.

This study indicates that if there is proper preparation and uniform protocol, such as that established by Charnley and others,[11,12] total hip replacement can be performed effectively in a community hospital by the orthopedic surgeon. It is essential that proper attention be given to the medical preoperative preparation of patients undergoing this operation. The participating orthopedic surgeon must realize that planning and discipline are necessary to obtain satisfactory results. This not only involves the proper selection of the patient and excellent execution of the operation but the procurement of appropriate medical support personnel to ensure a safe course for the patients.

Summary

Six hundred ninety total hip replacements were performed in a community teaching hospital in the period of 1971 to 1975. There was an 8-percent complication rate related to the surgery and a 25-percent medical complication rate associated with the operation. Comparative studies of results of total hip replacements performed in large specialty centers revealed that the community hospital setting had comparative values. However, it is important to emphasize that a rigid protocol was followed in the community hospital setting. Satisfactory results obtained in the community hospital setting demonstrate clearly the general application of total hip replacement; however, discipline and forethought are essential.

Generic and Trade Name of Drug

Crystalline sodium warfarin — Coumadin (Emco Co.)

References

1. Charnley J: Arthroplasty of the hip: A new operation. *Lancet* 1:1129-1132, 1962.
2. McKee GK: Development of total prosthetic replacement of the hip. *Clin Orthop* 72:85-103, 1970.
3. Mueller ME: Total hip prosthesis. *Clin Orthop* 72:46-68, 1970.
4. Ring PA: Complete replacement arthroplasty of the hip by the Ring prosthesis. *J Bone Joint Surg* 50B:720-731, 1968.
5. Patterson FP, Brown CS: The McKee Farrar total hip replacement: Preliminary results and complications of 368 operations performed in five general hospitals. *J Bone Joint Surg* 54A:257-275, 1972.
6. Wilson PD Jr, Aglietti P, Salvati EA: Subacute sepsis of the hip treated by antibiotics and cemented prosthesis. *J Bone Joint Surg* 56A:879-898, 1974.
7. Charnley J: The long-term results of low-friction arthroplasty of the hip performed as a primary intervention. *J Bone Joint Surg* 54B:61-76, 1972.
8. Coventry MB, Beckenbaugh RD, Nolan DR, et al: 2,012 total hip arthroplasties: A study of postoperative course and early complications. *J Bone Joint Surg* 56A:273-284, 1974.
9. Murray WR: Results in patients with total hip replacement arthroplasty. *Clin Orthop* 95:80-90, 1973.
10. Mallory TH: Hypotensive anesthesia in total hip replacement. *Orthopaedic Review* 4(8):21-30, 1975.
11. Charnley J: Total hip replacement by low friction arthroplasty. *Clin Orthop* 72:7-21, 1970.
12. Wiles P: The surgery of the osteoarthritic hip. *Brit J Surg* 45:488-497, 1958.

journal Advertisers

American Emergency Medical Services....68
Breon Laboratories Inc.....5
Brown Pharmaceutical Company Inc. 6, 7, 17
Burroughs Wellcome Co.....52, 53
Daniels-Head and Associates.....33
Immke Circle Leasing.....35
International Travel Advisors.....2
Lilly, Eli and Company.....60
Mead Johnson.....37, 38, 39, 40
Medical Protective Company..... 66
Medical World News.....11
Mediclinics, Inc 45
Menedian Carpets 41
Merck, Sharp and Dohme.....21, 22, 70, 71
Ohio Medical Indemnity.....28
OSMA Annual Meeting.....12, 59
New Orleans Graduate Medical Assembly...35
Pharmaceutical Manufacturers Association 46, 47
Physicians Insurance Company of Ohio....48
Practice Productivity, Inc.....56
Roche Laboratories, Div. of Hoffmann-LaRoche, Inc. .....Cover 2, 62, 63, 64, Cover 3, Cover 4
Schmidt's Sausage Haus.....57
Turner and Shepard, Inc.....57
Warren-Teed Laboratories.....18, 19
Wendt-Bristol Company 49
Windsor Hospital 33



If Our Area Manager Isn't In Maybe Our Secretary Can Help

Our Blue Shield professional relations managers are busy people, constantly out calling on doctors and their office staffs. Which means that if you phone, the area manager may not be in at that moment.

However, expert help may still be available. The area office secretaries are trained and capable in providing assistance with the more common and frequent kinds of matters.

They can check on the status or disposition of claims, answer questions about whether a certain service is payable under a specific contract or find out if the patient is a currently enrolled Blue Shield subscriber.

We take our service seriously...all of us.

Blue Shield

Ohio Medical Indemnity, Inc.

6740 North High Street, Worthington, Ohio 43085

Survey of Ohio Primary Physicians

A Projection of Future Needs to the Year 2000

Lauren M. Brown, M.D.
Tennyson Williams, M.D.

Primary core physicians in family practice, internol medicine, and pediatrics were surveyed. Compared to the ideal ratios used in the Lawton Study of Florida, Ohio has approximotely one-half the number of eoch of these primary core speciolists needed. In order to fill this need, as well as to compensote for population growth needs and physician ottrition replacement, approximately 131 new family proctice residency, first-year positions are required. Internal medicine and pediatric primary core needs may be met by converting o selected number of present positions into specific, primory care positions and adjusting the curriculum accordingly.

IN 1974, THE OHIO LEGISLATURE enacted House Bill 474. This legislation mandated the establishment of family medicine departments in all Ohio medical schools that receive any state subsidy.[1] At that time, four approved medical schools existed within the state. Since then two medical schools granting the M.D. degree and one medical school granting the D.O. degree have been established. As the family medicine departments became realities. it became imperative that someone survey the current primary care physician population of the state, the projected retirement of these physicians, the current population of Ohio and the projected population growth in order to establish desirable primary physician-to-population ratios. The Department of Family Medicine of The Ohio State University College of Medicine and the Graduate and Undergraduate Education Committee of The Ohio Academy of Family Physicians collaborated to conduct such a survey. The study was initiated before the American Medical Association had included obstetrics and gynecology in the primary care classification; therefore, the omission of this specialty is not intended to reflect disagreement with this classification.

Method

To determine who was practicing primary medicine in the State of Ohio at the time of the survey, each of the 88 counties was assessed separately. A family physician known personally to one of the investigators was identified in each county. A master list of physicians was prepared for each separate county using the American Medical Association and the American Osteopathic Association directories. These lists were validated and updated by these local physicians. In all cases, the final list was the responsibility of the local contacts. These categories of practicing primary physicians were identified:

1. *Family Physicians.*—M.D. family physicians/general practitioners; D.O. general practitioners; full-time emergency room physicians; and full-time school health physicians. These will be categorized as FPs in our survey.
2. *Primary Internists.*—Full-time subspecialists, such as

Dr. Brown, Akron, Active Staff, Barberton Citizen's Hospital, Courtesy Staff, The Ohio State University Hospitals; and Clinical Associate Professor, Department of Family Medicine, The Ohio State University College of Medicine.
Dr. Williams, Dublin, Attending Staff, The Ohio State University Hospitals, Courtesy Staff, Children's Hospital, Columbus, and Grady Memorial Hospital, Delaware, Ohio; and Professor and Chairman, Department of Family Medicine, The Ohio State University College of Medicine.
Submitted April 25, 1977.

cardiologists, hematologists, were deleted. This group will be referred to as IMs in our survey.

3. Primary Pediatricians.—Full-time subspecialists such as cardiologists, allergists, and others, were deleted. This group will be referred to as PDs in our survey.

After identifying these physicians, we determined each of their ages from directories, association records, and in a few cases, personal contacts.

A separate table was made for each county, and each identified practicing physician was projected as continuing practice until he reached the age of 65 years. While this may be an erroneous assumption, the increasing cost of malpractice insurance premiums precludes most physicians from continuing to practice to the ages customary in the past. A few early deaths will be compensated for by physicians older than 65 years who continue to practice. Five-year time spans were used: 1975, 1980, 1985, 1990, 1995, and 2000.

Each physician is counted as one unit until the five-year period when he/she reaches 65 years of age and is subsequently deleted from our figures. Any physician now practicing beyond the age of 65 years was counted as one-half a unit until 1980 when they were deleted. A summary of these figures by counties is shown in the Table.

The current population figures and the projected population growth for the five-year spans from 1975 until the year 2000 were obtained from the Human Resources Development Division of the Ohio Department of Economic and Community Development[2] and are summarized as follows:

1975	11,106,900
1980	11,617,800
1985	12,143,900
1990	12,676,000
1995	13,112,100
2000	13,554,100

These figures project a population increase of 2,447,-200 persons by the year 2000.

The literature was reviewed to determine a valid, ideal physician/patient ratio.[3-12] Knowles[3] and Schonfeld[4] have thoroughly addressed the variables which make such ratios difficult to assess.

The concensus of these reports is best expressed by Lawton,[6] and we have chosen to use his ratio of 45 FP/100,000 population, 25 IM/100,000 population, and 10 PD/100,000 population as the ideal figures.

Results

Presently, there are 2,766 FPs practicing in Ohio. The current deficit for the ideal relationship (one FP to 2,222 population) is 2,234 family physicians. An additional 1,101 new family practice physicians will be needed during the next 25 years to care for the increased population that has been projected. Also, 2,306 of the family practice physicians practicing now will cease practice and have to be replaced. Thus, 5,640 family physicians will be needed by the year 2000 to achieve optimal care for the citizens of our state (Fig. 1).

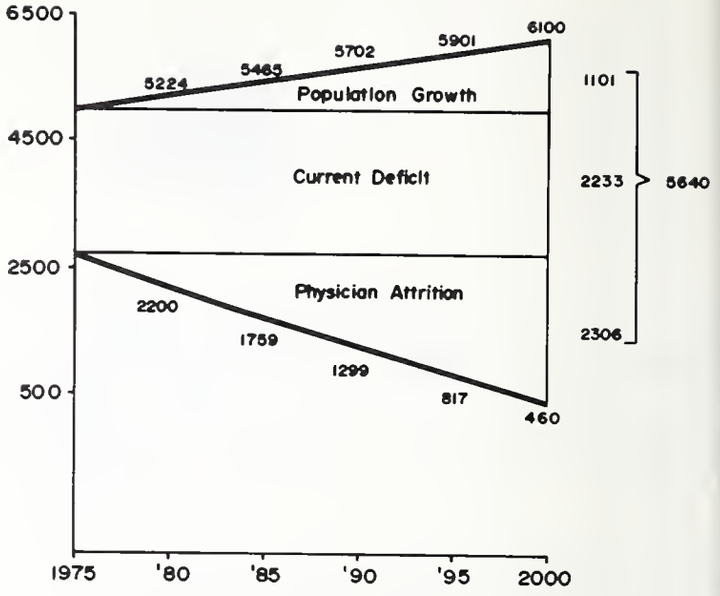


Fig. 1. Projected number of family physicians needed.

The figures for internal medicine are in similar ratios. In addition to the 1,406 deficit now existing for the ideal ratio of one general internist per 4,000 people, 612 new general internists will be needed for projected population increase, 981 for replacement, for a total of 2,999 new general internists needed by the year 2000 (Fig. 2).

General pediatrics shows a current deficit of 586, with 244 to fulfill projected population needs and 357 for

(continued on page 32)

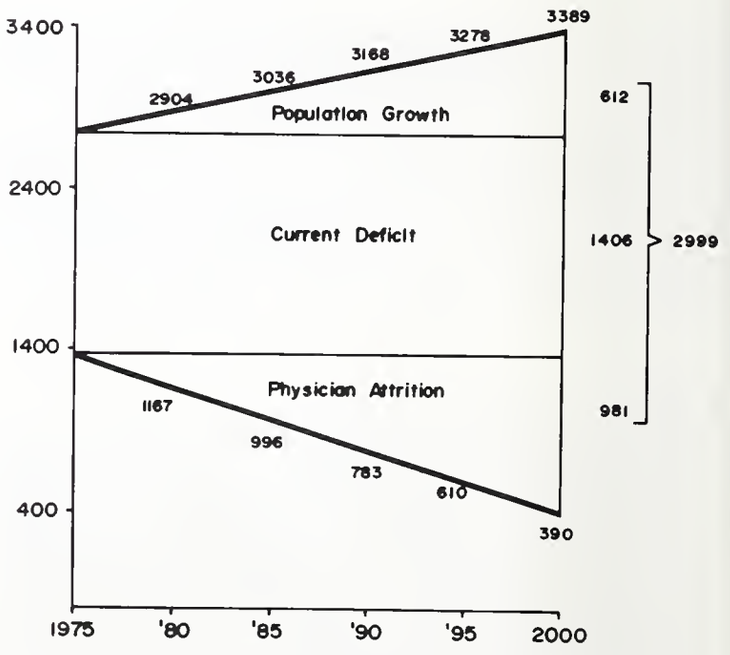


Fig. 2. Projected number of general internists needed.

1975 Ohio Primary Physician Manpower Study

Full-Time Equivalent Practitioners

County	1975			1980			1985			1990			1995			2000		
	FP	IM	PD	FP	IM	PD	FP	IM	PD	FP	IM	PD	FP	IM	PD	FP	IM	PD
Adams	4	1	0	4	1	0	4	1	0	3	1	0	3	1	0	1	1	0
Allen	30.5	5	2.5	23	5	2	19	5	2	14	5	2	3	0	2	1	0	1
Ashland	16.5	1	1	13	0	1	10	0	1	6	0	1	4	0	0	2	0	0
Ashtabula	21	7	2	15	6	1	13	5	1	8	4	1	6	4	1	3	3	1
Athens	18.5	1	3	11	1	2.5	9	1	2.5	6	1	2.5	3	1	2	2	1	2
Auglaize	17	1	0	13	1	0	10	1	0	8	1	0	6	1	0	3	1	0
Belmont	29.5	4	4	20	4	4	18	3	4	13	2	4	6	2	3	3	1	2
Brown	6.5	0	0	5	0	0	4	0	0	2	0	0	0	0	0	0	0	0
Butler	36	16.5	14	31	16	13	25	14	11	20	12	9	11	9	9	5	5	7
Carroll	3	0	0	3	0	0	2	0	0	1	0	0	1	0	0	0	0	0
Champaign	12	2	0	7.5	2	0	4	2	0	4	2	0	1	2	0	0	2	0
Clark	29.5	17	5	22.5	15	5	20	13	4	16	6	3	11	2	2	4	1	2
Clermont	17.5	2	1	15	2	1	15	2	1	9	1	1	5	1	0	1	1	0
Clinton	10.5	1	0	8	1	0	7	1	0	2	1	0	2	0	0	2	0	0
Columbiana	18.5	2.5	2.5	16	2	2	10.5	2	2	5.5	2	2	4.5	1	2	4.5	0	1
Coshocton	8.5	1	1	8	1	1	6	1	1	4	1	1	3	1	1	2	1	1
Crawford	18.5	3	0	14	3	0	13	3	0	8	2	0	3	2	0	2	2	0
Cuyahoga	262.5	298.5	93.0	229.5	250.0	77.5	131.0	203.0	62.5	100.5	146.0	42.5	54.5	127.0	20.5	22.5	47.0	9.0
Darke	20.5	1	0	16	1	0	15	1	0	9	1	0	8	1	0	6	1	0
Defiance	10.5	4.5	1	9	4	1	5	4	1	3	4	1	2	3	1	2	2	1
Delaware	12.5	1	0	8	1	0	7	1	0	5	1	0	4	1	0	2	1	0
Erie	29.5	8.5	3	18	6	3	15	5	3	13	4	1	8	4	0	5	2	0
Fairfield	26	2	2	22	1	2	18	1	1	16	1	0	10	0	0	7	0	0
Fayettte	9.5	1	1	7	1	1	5	1	1	3	1	1	0	1	1	0	1	1
Franklin	259.5	202.5	83	212	176	77	165	158	71	123	140	62	89	120	52	59	107	43
Fulton	16.5	0	0	13	0	0	12	0	0	8	0	0	4	0	0	2	0	0
Gallia	7	10.5	7	5	9.5	7	4	9	6	2	7	5	2	5	4	2	2	2
Geauga	10.5	5	1	9	5	1	9	4	1	7	4	1	2	3	1	0	2	0
Greene	29	8	5	24	7	5	21	5	5	13	5	4	9	5	3	6	3	1
Guernsey	11	3	2	10	3	2	6	3	2	4	3	2	2	3	2	2	2	2
Hamilton	200.0	234.5	87.0	149.0	184.5	81.0	127.0	158.0	57.5	81.0	115.5	48.5	37.0	70.5	29.5	17.0	42.0	19.0
Hancock	12.5	12	1	10	11	1	9	9	1	8	7	1	4	6	0	1	6	0
Hardin	7	3	0	5.5	3	0	2	2	0	2	1	0	1	1	0	1	0	0
Harrison	7	1	0	5	1	0	5	1	0	3	1	0	2	1	0	2	1	0
Henry	5	0	0	4	0	0	4	0	0	2	0	0	1	0	0	0	0	0
Highland	10	2.5	1	6	2.5	1	6	2.5	1	3	2.5	1	2	2	1	0	2	1
Hocking	8.5	.5	1	6	0	1	5	0	1	5	0	1	4	0	1	4	0	1
Holmes	8	0	0	6	0	0	6	0	0	6	0	0	4	0	0	2	0	0
Huron	10.5	1	0	9	1	0	9	1	0	7	1	0	3	1	0	0	0	0
Jackson	10.5	0	0	9	0	0	4	0	0	4	0	0	3	0	0	1	0	0
Jefferson	22.5	13	2	15.5	12.5	1	15	11	1	8	10	1	5	8	0	3	5	0
Knox	12	3.5	3	10	3	2	9	2	2	6	2	2	5	2	2	4	1	2
Lake	37.5	12	7.5	26	10	5.5	24.5	8	5.5	20.5	6	3	14.5	4	2	7	1	1
Lawrence	10.5	1.5	1	8	1	1	7	1	0	6	0	0	5	0	0	2	0	0
Licking	34	4	3	26	4	3	23	3	1	18	2	1	14	1	1	9	0	1
Logan	14	3	2	12	3	2	10	3	2	7	3	2	6	3	1	3	1	1
Lorain	77	15	8.5	64	13	7	54	11	5	38	8.5	4	25	6	4	18	5	2
Lucas	215	117	48	178	102	46	145	89	43.5	110.5	74	39.5	73	60	33.5	43	49.5	25.5
Madison	11.5	1	0	10	1	0	8	1	0	5	1	0	4	1	0	1	1	0
Mahoning	63.5	45.5	11.5	36	41.5	9	29.5	36.5	9	26	28	7	15	20	6	9	12.5	5
Marion	11	12	4.5	4.5	12	4	2.5	9	4	2	6	3	1	5	2	1	5	1
Medina	20.5	2	2	19	2	2	15	2	2	7	1	2	3	1	1	3	1	1
Meigs	5	0	0	3	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Mercer	11	0	0	10	0	0	5	0	0	4	0	0	4	0	0	2	0	0
Miami	31	7	2.5	24.5	5	2	22.5	5	2	19.5	4	1	14	4	1	5	3	1
Monroe	2	0	0	1.5	0	0	1	0	0	1	0	0	1	0	0	1	0	0
Montgomery	234.5	74.5	28	189	65	25	166	55	21	138	47	16	96	37	12	61	18	8
Morgan	2.5	0	0	1	0	0	1	0	0	1	0	0	1	0	0	0	0	0
Morrow	4	0	0	3	0	0	1	0	0	0	0	0	0	0	0	0	0	0
Muskingum	16.5	2.5	4.5	10	2	4	8	2	3	4.5	2	3	2	0	3	0	0	3
Noble	3.5	0	1	3	0	1	3	0	1	3	0	1	1	0	1	0	0	0
Ottawa	13	1	0	12	1	0	11	1	0	9.5	1	0	5.5	1	0	3.5	1	0
Paulding	7	0	0	6	0	0	4	0	0	3	0	0	3	0	0	2	0	0
Perry	4.5	0	0	3	0	0	3	0	0	1	0	0	0	0	0	0	0	0
Pickaway	12.5	0	0	11	0	0	9	0	0	6	0	0	4	0	0	2	0	0
Pike	7.5	.5	.5	6	0	0	5	0	0	3	0	0	3	0	0	1	0	0
Portage	37.5	6	3	34	5	3	32	4	2	20	3	1	13	2	1	7	1	1
Preble	12.5	0	0	10	0	0	8	0	0	7	0	0	4	0	0	3	0	0
Putnam	6	0	0	6	0	0	5.5	0	0	3.5	0	0	2	0	0	1	0	0
Richland	24.5	18	4	18	14.5	4	13	13.5	4	8	6	3	5	4	3	2.5	3	2
Ross	13	4	3	10	4	3	8	3	3	4	2	1	1	2	1	1	2	0
Sandusky	17	2.5	0	10	2	0	6	1	0	4.5	1	0	3	1	0	0	1	0
Scioto	27.5	4	2.5	16	4	2	12	4	2	9	4	1	5	3	0	1	3	0
Seneca	17	6	3	14	6	3	10	4	3	9	4	2	2	3	1	1	1	1
Shelby	7	1	0	7	1	0	6	1	0	5	1	0	5	1	0	4	1	0
Stark	89.5	56	18	72	41	16	62	34	14	49	23	13	32	18	9	17	12	7
Summit	120.5	52	22.5	102	47	19	90	40	15	70	30	9	45	15	7	28	9	6
Trumbull	72	19.5	9	62	18	9	55	17	9	44	17	8	24	17	7	14	6	1
Tuscarawas	33.5	4	1	23.5	4	1	19.5	3.5	1	12.5	2.5	.5	7.5	2	0	4.5	1	0
Union	10.5	1	0	9	1	0	7	1	0	3	1	0	0	1	0	0	0	0
Van Wert	10	1	0	8.5	1	0	7.5	0	0	3	0	0	3	0	0	1	0	0
Vinton	2	0	0	2	0	0	2	0	0	2	0	0	2	0	0	2	0	0
Warren	18.5	0	0	15	0	0	15	0	0	10	0	0	8	0	0	2	0	0
Washington	10	2.5	1	7	1	1	6	1	1	2	1	1	2	1	1	1	1	0
Wayne	29	6	2	27	6	2	18	3	2	11	2	1	6	1	1	3	1	0
Williams	12.5	4.5	2	11	4	2	9	2	2	8	2	2	6	2	2	5	2	1
Wood	25	2.5	0	18	2	0	14	2	0	7	2	0	6	2	0	3	2	0
Wyandot	6	0	0	5	0	0	6	0	0	3	0	0	2	0	0	0	0	0
Totals	**2766**	**1371**	**525**	**2200**	**1167**	**473**	**1773**	**996**	**404**	**1299**	**783**	**326**	**817**	**610**	**241**	**461**	**390**	**168**
Needed	**5000**	**2777**	**1111**	**4728**	**2904**	**1161**	**5465**	**3036**	**1215**	**5702**	**3167**	**1268**	**5902**	**3279**	**1321**	**6101**	**3390**	**1356**
Deficit	**7234**	**1406**	**586**	**2528**	**1737**	**688**	**3692**	**2040**	**811**	**4403**	**2384**	**942**	**5085**	**2669**	**1080**	**5640**	**3000**	**1188**

replacement, for a total of 1,187 new pediatricians (Fig. 3).

Discussion

The foregoing figures reflect a need for 5,640 additional family practitioners, 2,999 additional general internists, and 1,187 additional general pediatricians by the year 2000. To fulfill these needs, residency positions are needed to train physicians in these specialties. A review of residency positions now available in Ohio, as indicated in the *Directory of Accredited Residencies 1975-1976,* shows there are 251 first-year positions for internal medicine and 92 first-year positions in pediatrics.[13]

There is no data to reveal how many of these internal medicine and pediatric residence positions are structured for primary care training in these specialties. The data presented here supports, on a statewide basis, that there is need for a change in the emphasis of certain numbers of internal medicine and pediatric residency positions, rather than the creation of additional primary care positions in these specialties.[14] Furthermore, these data present to those responsible for such a decision a basis for determining the number of positions that should be converted to a primary care orientation.

In family medicine, however, the situation is vastly different. The need for 5,640 additional family physicians will require 225 first-year family medicine positions. Currently, there are 94 such positions available in Ohio,[15] resulting in a need for 131 additional positions. To ensure the orderly growth of quality, family practice residency positions to meet this goal in Ohio, it is appropriate that medical school deans, the Ohio Board of Regents, and the State Legislature give priority to the allocation of available financial and human resources. Data presented in this paper should be useful in the process.

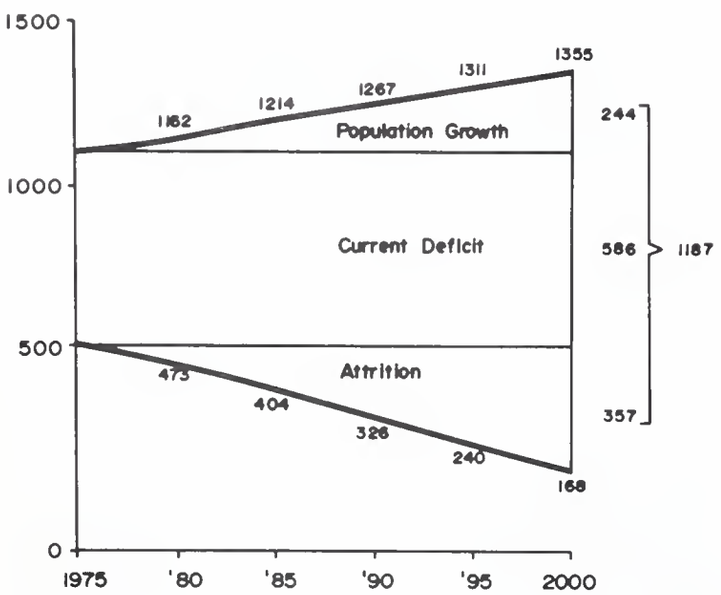


FIG. 3. Projected number of general pediatricians needed.

The conclusions assume the numbers of residency positions mentioned will be filled; that physician importation and exportation in and out of Ohio will be equal; that the current deficit should be resolved over a 25-year period; and that determinants of health care will not change in the projected time frame. While these assumptions are naive, it is suggested that the data represent a rational basis for establishing state policy, priorities, and short-term planning. It is planned to repeat the study every five years with adjustments in the assumptions and conclusions appropriate to the intervening circumstances.

It is also appropriate to note that this is the first study to separate physician-manpower needs into the three elements of current deficit, population growth needs, and physician-attrition replacement. This gives a basis for long-range planning to recognize that the resources dedicated to resolving the current deficit no longer will be needed at some future point, and can be either terminated or diverted in an orderly fashion to achieving other goals.

Summary

A deficit of primary physicians exists in the State of Ohio. This deficit exists at least in the specialties of family practice, internal medicine, and pediatrics. Sufficient residency positions are presently available in internal medicine and pediatrics to train an adequate number of physicians in these specialties, although training emphasis may need to be redirected for a portion of the positions. For a more rational decision, further study may be needed in these fields to determine the number of residency graduates that now go into primary care practices. Family practice, while growing, has a deficit of 131 first-year residency positions. A concerted effort with continuing and increasing support is needed to expand family practice programs within the State of Ohio.

Acknowledgements: The authors are grateful to Eileen E. Merrick for following up contacts, tabulating results, and typing the manuscript; and to Florence I. Landis for acting as liaison with the Ohio Academy of Family Practice and for identifying local physicians to review and update the physician lists.

References

1. Ohio Legislature. 110th General Assembly: *Amended House Bill 474,* Regular Session 1973-74.
2. U.S. Health Resources Development Bureau: *The Supply of Health Manpower, 1970 Profiles and Projections to 1990,* Series P-25. DHEW Publication No. (HRA) 75-38, December 1974.
3. Knowles JH: The quantity and quality of medical manpower: a review of medicine's current efforts. *J Med Ed* 44:81-118, 1969.
4. Schonfeld HK, Heston JF, Falk IS: Numbers of physicians required for primary medical care. *N Engl J Med* 286: 571-576, 1972.
5. Lewis RV: A survey of physicians of Rhode Island and an evaluation of needs. *Rhode Island Med J* 58:161-165, 1975.
6. Lawton RP: A Report on Physician Distribution in Florida,

in *Florida Regional Medical Program,* prepared for Community Hospital Education Council, June 1973.
7. Mayo F: *Primary Physician Manpower in Virginia, 1972, Present Supply and Future Needs,* mimeograph copy, Dept. of Family Medicine, Medical College of Virginia.
8. *Physician Manpower and Distribution in Florida,* State University System of Florida, Community Hospital Education Council, May 1976.
9. Steinle JG: Suggested ratio of physician to population. *Hosp Top* 49:44, 1971.
0. True RM, Caven RE, Frechette RP: Health planning for primary care in rural shortage areas. *J Maine Med Assoc* 67:326-333, 1976.
11. How many people to support a specialist. *Med Economics* 44:67-70, 1967.
12. Paxton HT: Doctor shortage? Its narrowing down to primary care. *Med Economics* 50:104-107, 1973.
13. *Directory of Accredited Residencies.* Liaison Committee on AMA Graduate Education, 1975-76.
14. Morrow JH, Edwards AB: U.S. health manpower policy: will the benefits justify the costs? *J Med Ed* 51:791-805, 1976.
15. *NIRMP Directory.* Hospitals and Programs Participants in the Matching Program for 1977 Appointments, National Intern and Resident Matching Program, October 1976.



WINDSOR HOSPITAL
A NONPROFIT CORPORATION
— ESTABLISHED 1898 —
Chagrin Falls, Ohio
247 - 5300
A hospital for the treatment of Psychiatric Disorders
High on a Hill-Top, Overlooking Beautiful Chagrin River Valley.
Accredited by Joint Commission on Accreditation of Hospitals.
Booklet available on request.
FRIEDRICH A. LINGL, M.D. Medical Director
GUY H. WILLIAMS, JR., M.D. Medical Director Emeritus
HERBERT A. SIHLER Jr. President
MEMBER: American Hospital Association—National Association of Private Psychiatric Hospitals

we can provide some form of health insurance to . . .
99%
of OSMA members—regardless of health history

Comprehensive protection is available for you and your family with the OSMA sponsored Hospital Confinement Insurance Plan, comprehensive Major Medical Insurance and the Excess Major Medical Insurance Plan. Also available to Ohio physicians are Disability Income Coverage, Practice Overhead Expense Coverage, Life Insurance and Accidental Death, Dismemberment and Disability Insurance. Choose the plans that fill your insurance needs and send the coupon today for complete details. Or better yet for immediate information, call us collect!

Spencer W. Cunningham
DANIELS-HEAD & ASSOCIATES, INC.
Daniels-Head Building
Portsmouth, Ohio 45662
Telephone 614/354-4561

I have checked the plans in which I am most interested. Please send me complete details on how I can take advantage of this high value insurance protection at low group rates.
OSMA SPONSORED PLANS
☐ HOSPITAL CONFINEMENT INSURANCE PLAN
☐ COMPREHENSIVE MAJOR MEDICAL INSURANCE
☐ EXCESS MAJOR MEDICAL INSURANCE
ALSO AVAILABLE TO OHIO PHYSICIANS
☐ DISABILITY INCOME PROTECTION
☐ ACCIDENTAL DEATH, DISMEMBERMENT and DISABILITY INSURANCE
☐ PRACTICE OVERHEAD EXPENSE PROTECTION
☐ LIFE INSURANCE
Name_____
Address_____
City_____
State_____ Zip_____

THE OHIO STATE Medical Association Cancer Education Series*

The Cancer Committee

Tom F. Lewis, M.D.

A CANCER COMMITTEE may adopt any appropriate name. Since its inception in 1955, the one at Mt. Carmel Medical Center in Columbus has had several names. When our only activity was registry, 22 years ago, we were known as the Cancer Registry Committee. Later, we added a monthly tumor conference and accepted the responsibilities of a Tumor Board, so called. As the Committee considered the term "tumor board" to be presumptuous, we became — and still are — the Cancer Activities Committee.

One of the absolute requirements for establishing such a committee is the presence of at least one staff member who has an interest in cancer and who will spearhead future development in terms of other interested personnel, funding, promotion, and possibly most important, stimulate the concern of the entire medical staff.

The organization of the cancer registry is *primary*. The medical staff should have an interest in it; if such an interest is missing, it must be developed by frequent reference to the work of the registry. A registry cannot exist without the follow-up data furnished by the staff.

The hospital administration must be impressed with the need for such record keeping. The ease or difficulty with which this can be accomplished will depend upon each administrator's background and his rapport with the Committee. Personnel problems are endless and require responsible administrative help.

The Committee's principle aims are to provide: (1) improved patient care; (2) a multidisciplinary educational program; and (3) registry guidance.

Improving Patient Care.— Almost every function of the Cancer Committee is related to improving patient care in some manner, however, there are several specific ways the Committee can affect some measurable methods of interpreting the quality of patient care in the institution.

First, and probably the newest technique available, is participation in the Professional Standards Review Organization (PSRO) program. One of the requirements added to our cancer program is active participation in the evaluation of cancer patient care. This process is carried out in conjunction with the PSRO Committee, with the Cancer Committee directly supervising the establishment of criteria and interpreting the results.

Our Committee has completed two studies on patient care evaluation and is beginning work on a third. The results have been very informative, and educational programs are being established to discuss some of the criteria.

The tumor board of the hospital can greatly enhance the quality of care for cancer patients. Our members have been carefully selected on the basis of experience with the cancer patient and the willingness to learn and to expand their knowledge of cancer care. Their participation in educational conferences is a valuable asset in ensuring a well-informed staff.

We have established a Cancer Fund whereby patients' families and other interested persons can contribute money directly to the cancer program. The Committee can direct the expenditure of funds for the acquisition of equipment and educational supplies to improve the overall cancer program.

Providing a Multidisciplinary Educational Program.— Again, it is most important that those chosen for the Cancer Committee be carefuly selected. The Committee should consist of members of each medical discipline involved in the care of the cancer patient. They should be willing to participate in the organization of educational conferences.

The multidisciplinary cancer conferences furnish an excellent atmosphere for education. Our conferences have received one hour of AMA Continuing Medical Education credit, and this has greatly increased the attendance. The format usually is prospective in nature and is carefully organized to allow all members of the staff to participate.

Members of the Family Practice Group at our insti-

Dr. Lewis, Columbus, Chairman, Cancer Activities Committee, Mt. Carmel Medical Center, Columbus, Ohio.
Submitted August 3, 1977.

The Journal is pleased to publish this series through the cooperation of the OSMA Committee on Cancer and the American Cancer Society, Ohio Division Inc.

tution are encouraged to participate; two of them have been appointed to our Committee. Through them, the educational experiences can be carried into the community with special emphasis placed on the early detection of malignancies.

Registry Guidance.— Careful supervision of the cancer registry results in improvement of the overall program. Our registrar is aware of our objectives and is guided toward the accomplishments of these objectives. She participates in the selection of topics for our conferences and keeps attendance records and minutes of both our committee meetings and our conferences.

Our Committee takes an active role in encouraging the use of our registry. Seven reports have been requested from the registry in the first four months of 1977 for use in conferences. When reports are requested, our registrar is given detailed information concerning the data needed and the type of presentation for which the report will be used. In this way, we can ensure meaningful data and proper presentation of reports.

Our residents have found the registry to be a valuable source of information for reports and lectures. It is highly recommended that each resident be informed as to the content of the cancer registry.

We believe that, with innovative ideas and some extra effort, the Cancer Committee of the community hospital can serve a meaningful purpose to the cancer patient in the hospital and in the community.

Announcing the

41st ANNUAL NEW ORLEANS MEDICAL ASSEMBLY

March 31 - April 4, 1978

The Fairmont — New Orleans

THE HIGH RISK PATIENT

Accreditation: AMA Category I, Physicians' Recognition Award, American Academy of Family Practice, American College of Emergency Medicine, Category I.

Adolph A. Flores, Jr., M.D., President; Oliver H. Dabezies, Jr., M.D., F.A.C.S., Director of Program.

Registration Fee: $200 non-member physicians; $100 military; $100 registered nurses; Complimentary: students, residents, interns and Fellows.

Write or Phone: New Orleans Graduate Medical Assembly, Room 1538, Tulane Medical Center, 1430 Tulane Ave., New Orleans, LA 70112. Call (504) 525-9930.

• Presidential Reception • Exhibitors' Champagne Reception • Mississippi River Cruise aboard SS Natchez • Superdome Tour, luncheon & fashion show for wives & guests.

Spring Fiesta, March 31, 1978. "A Night in Old New Orleans", Jackson Square.

IMMKE CIRCLE LEASING INC

Endorsed Leasing Company
Of The Ohio State Medical Association

Immediate delivery on many 1978 models

We lease all foreign and domestic makes and models including Mercedes, Jaguar, Porsche, etc.

Immke Circle Leasing, Inc.
32 South Fifth Street
Columbus, Ohio 43215

Telephone 614-228-1701 or
Toll Free 1-800-282-0256

THE OHIO STATE Medical Association News

Economics in Purchasing Medical Professional Liability Insurance

Hart F. Page, C.A.E.
OSMA Executive Director

As a member service, the Ohio State Medical Association takes this opportunity to point out some economics involved in purchasing medical professional liability insurance. Now that the private market has reopened in Ohio, physicians will find that possibly the most expensive place to purchase medical professional liability insurance is the Joint Underwriting Association (JUA).

The insurance offered by the JUA has two major drawbacks which escalate its cost. First, the policy sold by the JUA is the "claims-made" variety. This means that the contract provides protection only for the year it is in force. If a physician discontinues a "claims-made" policy, he must purchase "tail" coverage for the period(s) of the claims-made policy(ies).

It should be noted that the charge for the "tail" coverage increases with every year the insured stays with the JUA or any other company offering "claims-made" policies. The OSMA **strongly urges** any physician leaving a "claims-made" policy to purchase "tail" coverage so that he will have insurance protection for the period of the "claims-made" policy. (For example, purchase of "tail" coverage would be necessary if an individual went from a "claims-made" to an occurrence policy.)

Second, the law which set up the JUA requires that a surcharge be collected at the time of policy purchase. This surcharge is placed in the Stabilization Reserve Fund. Physicians should be aware that the surcharge is in the amount of 100 percent of the policy premium to a maximum of $5,000. This surcharge is applied **every** year the insured remains with the JUA.

This information is offered in order to help OSMA members make prudent, economic, and intelligent decisions regarding purchase of medical professional liability insurance. The OSMA Staff or the Physicians Insurance Company of Ohio stand ready to assist member physicians make this decision should they desire such help. Contact the Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215 (phone: 614/228-6971) or the Physicians Insurance Company of Ohio, 6100 Channingway Boulevard, Columbus, Ohio 43227 (phone: 614/864-3043).

Academy of Family Physicians Offers Examination Workshops

The American Academy of Family Physicians will hold a series of workshops to assist practicing family physicians to take the certifying examination in family practice. The workshops will be held at eight sites throughout the nation from January through March, 1978. The August 1978 certifying examination will be the last one for which family physicians who have not completed a family practice residency may be eligible. Subsequent examinations will be open only to physicians who have completed an approved residency training program. The cutoff date to apply to take the examination is April 1, 1978.

Dates and sites of the workshops are: January 7, Atlanta, Georgia; January 8, Arlington, Texas; February 24, Denver; February 25, Portland, Oregon; February 26, Los Angeles; March 3, Philadelphia; March 4, Bloomington, Minnesota; and March 5, Chicago. For further information, write Education Division, American Academy of Family Physicians, 1740 West 92nd Street, Kansas City, Missouri 64114, phone: 800/821-2512. There is a $50 fee to offset expenses.

Plan to Attend AMA National Leadership Conference

The theme for the AMA's Sixth National Leadership Conference is "Synergy in Leadership." The conference will be held January 26-29, 1978 at the O'Hare Marriott Motor Hotel, Chicago. The program for the meeting will focus on health care costs. Seven optional seminars will be held on Thursday, January 26.

Physicians' Assistance Requested In Identification of Child's Body

The Ashland County Sheriff's Office has requested assistance in identifying a child's body found near Interstate 71 on October 28, 1977. The child, a Black male, two-to-three years of age, had died of a blow to the head. The right arm was in a cast; the simple fracture of the right distal radius, one-and-one-half inches from the wrist, appeared to be about one month old. The cast was not very professional: it barely extended above the elbow; instead of a stocking, two-to-three layers of surgical gauze and layers of cotton were used. The fracture was estimated to have occurred about September 28, 1977. The left arm was fractured recently, but was not in a cast.

The body bore evidence of previous child-beatings (apparently, prior to the beating just before the body was found). There were scars covering the back, buttocks, and legs of approximately the same age as the fracture. The beating(s) were believed to have been administered by use of an electrical cord or wire coat hanger.

(continued on page 61)



Simple drops of water help make COLACE® the most widely used stool softener.

COLACE®
dioctyl sodium sulfosuccinate

COLACE works by stool-softening action alone, free from laxative stimulation. Simply by letting natural intestinal water permeate stools, COLACE helps to eliminate the hard, dry stools common to constipation.

COLACE works to prevent pain and straining at stool with minimum chance of griping or cramps, particularly in patients with delicate anorectal disorders. COLACE is safe and non-habit forming in short- or long-term therapy. COLACE—the simple water way to ease constipation from infancy to old age. Capsules, syrup or liquid.

Mead Johnson PHARMACEUTICAL DIVISION
Evansville, Indiana 47721 U.S.A.

COMPATIBILITY



Eastern Tiger Swallowtail Butterfly
(Papilio glaucus)

Does it influence your choice of a peripheral/cerebral vasodilator*?

Vasodilan–compatible with coexisting diseases (e.g., glaucoma, diabetes)

Vasodilan has not been reported to affect the course of coexisting disease; it has not been reported to affect blood sugar levels or to raise intraocular pressure.

Vasodilan–compatible with concomitant therapy

Vasodilan has not been reported to affect the treatment of coexisting disease; it is compatible with such drugs as hypoglycemics and miotics.

Vasodilan–compatible with your total regimen for vascular insufficiency

Vasodilan can be a valuable adjunct in planning a total therapeutic program for vascular insufficiency.

*__Indications:__ Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg. Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily. Intramuscular: 5 to 10 mg.(1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

U.S. Pat. No. 3,056,836



VASODILAN® 20-mg tablets

(ISOXSUPRINE HCl)

20 mg q.i.d. recommended dosage

Mead Johnson
PHARMACEUTICAL DIVISION

© 1978 MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA 47721 U.S.A. MJL 7-4237R

This asthmatic isn't worried about his next breath...



he's active he's effectively maintained on

QUIBRON®

Each capsule or tablespoon (15 ml) elixir contains theophylline (anhydrous) 150 mg and glyceryl guaiacalate (guaifenesin) 90 mg. Elixir: alcohol 15%

- high theophylline for effective around-the-clock therapy
- 100% free theophylline
- individualized theophylline dosage schedule

Indications: For the symptomatic treatment of bronchospastic conditions such as bronchial asthma, asthmatic bronchitis, chronic bronchitis, and pulmonary emphysema.
Dosage: Initial: Adults: 1-2 capsules or 1-2 tablespoonfuls elixir every 6-8 hours, children 8-12: 1 tablespoonful or one capsule every 6-8 hours and children under 8: 3 to 5 mg theophylline/kg body weight every 6-8 hours. Theophylline dosage may be cautiously increased to 2000 mg/24 hr in adults or 7 mg/kg in children; monitoring of serum theophylline levels at higher dosages is recommended.
Precautions: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other xanthine derivatives concurrently. Use in case of pregnancy only when clearly needed.
Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea and vomiting. The frequency of adverse reactions is related to the serum theophylline level and are not usually a problem at serum theophylline levels below 20μg/ml.
How Supplied: Capsules in bottles of 100 and 1000 and unit-dose packs of 100; Elixir in bottles of 1 pint and 1 gallon.

Mead Johnson
PHARMACEUTICAL DIVISION

© 1978 Mead Johnson & Company • Evansville, Indiana 47721 U.S.A. MJL 6-4220R

Report on the First Session of the 112th Ohio General Assembly

D. Brent Mulgrew, J.D., Director, and
Richard A. Ayish, Assistant Director,
OSMA Department of State Legislation

The Second Session of the Ohio General Assembly opened January 3, 1978. During the past 12 months, more than 1,500 bills have been introduced; and 225 bills have been enacted into law. This amount of legislative activity has kept the OSMA Department of State Legislation very busy in the Statehouse. One hundred twenty bills have been introduced that could affect the practice of medicine. The Department has actively lobbied over 40 bills and monitored untold others.

The OSMA's legislative program has been very successful so far. Three major bills strongly supported by the OSMA have become law: HB 213, revising Ohio's informed consent statute; HB 725, amending last session's mentally ill commitment procedures bill; and SB 299, extending the Joint Underwriting Association.

Not one bill opposed by the OSMA has been enacted without the addition of OSMA-supported amendments. Although the drug anti-substitution law was repealed, a number of OSMA-supported changes were added, including a cost-savings pass-through to the consumer, a waiver of physician liability in case of faulty substitution by a pharmacist, and a retention of a physician's right to prohibit substitution.

The OSMA initially opposed the creation of a separate Physician Therapy Board, but modifications were made to the new definition so that most of the concerns of the OSMA were resolved. In addition, the law mandates a physician member of the new board.

Many other bills that concern the OSMA have not yet become law. SB 163, the optometric "diagnostic drug" bill remained stalled in the Senate. Physician contacts with members of the General Assembly remain the only way that organized medicine can offset the tremendous pressure of the Ohio Optometric Association members.

The so-called "Hospital Patients' Bill of Rights" (SB 202) has been substantially amended to meet many of the objections raised by organized medicine. It is now in the House Reference Committee awaiting committee assignment. SB 240, the bill permitting all professions to advertise, was amended and still prohibits the solicitation of patients.

Certificate-of-need legislation will continue to be a major issue in 1978. The Senate (SB 349), the House (HB 864), and the State Department of Health are all working on certificate-of-need bills or regulations. The OSMA will continue to push for an exemption in these proposals for physicians' offices.

The bill proposing creation of a State Department of Health Finance and Planning (HB 490) may begin to move in January. Two major provisions of the bill propose to remove health planning from the Department of Health and transfer the administration of the Medicaid program to the new department.

The Department of State Legislation presents the policies of the OSMA to the members of the Legislature. The task of influencing legislative decisions on medical issues cannot be accomplished in Columbus only. It is important for physicians at the local level to be involved. With so many important medical issues pending before the Ohio General Assembly, the creation of an effective local-physician contact system is essential. The development of physician involvement at the "grass roots" level can cement the work done by the Department staff in Columbus.

(continued on page 42)

The charts on pages 42-45 give a synopsis of bills monitored by the OSMA Department of State Legislation during the First Session of the 112th Ohio General Assembly. Bills introduced in the House are listed first, followed by those introduced in the Senate.

In Columbus
for over 65 years, since 1909,
K. A. Menendian
has been known for
the finest quality and best values in
ORIENTAL RUGS.

We carry a complete selection of rugs from mats to mansion sizes. Over 1500 rugs in stock from Iran, India, China, Pakistan, Turkey, etc.

See over 4,000 samples in our newly remodeled carpet showroom from Karastan and other fine mills.

We specialize in Oriental rug cleaning and repairing.

K.A.Menendian
1090 West Fifth Avenue
294-3345



Bill	Sponsor	Subject	Current Status
		BILLS INTRODUCED IN HOUSE	
HB 8	Branstool	Exempts insulin from sales tax	Ways and Means
HB 76	Healy	Repeals fluoride requirements in public water supplies	Governmental Affairs
HB 115	Tranter	Repeals motorcycle helmet law	Passed House, approved by Senate Highways & Transportation 7-27-77
HB 137	Deering	Registration of sanitarians	Law, effective 8-15-77
HB 151	Orlett	Repeals Ohio's anti-substitution drug law	Judiciary
HB 162	Jones	Requires motorcycle education courses	Education
HB 164	Leonard	Extends deadline for hearings of hospitalized mentally ill persons required by HB 244	Law, effective 2-21-77
HB 167	Maddux	Requires legislative purpose statements for all bills	Finance
HB 169	Maddux	Establishes minimum educational requirements for emergency medical personnel	Governmental Affairs
HB 177	Deering	Revises payment of state subsidies to health districts	Finance and Appropriations
HB 185	Saxbe	Repeals motorcycle helmet requirement	Transportation & Urban Affairs
HB 191	Shoemaker	Governor's biennial appropriations bill	Law, effective 6-30-77
HB 204	Lehman	Requires signs warning persons with pacemakers that microwave ovens are present in food establishments	Health and Retirement
HB 209	Rankin	Transfers regulation of physical therapists from State Medical Board to Board of Physical Therapy	Law, effective 11-21-77
HB 213	Murdock	Amends informed consent statute	Law, effective 11-24-77
HB 252	Begala	Establishes a department of geriatric medicine at state supported medical schools	Law, effective 7-1-78
HB 267	Lehman	Provides for jury exemption of physicians at their request; repeals automatic exemption	Law, effective 11-9-77
HB 282	Bell	Appropriation for sickle cell anemia research	Finance and Appropriations
HB 298	Nader	Determination of death	Judiciary
HB 319	Cook	Clarifies statute of limitation in product liability & establishes 12-year statute of limitation	Passed House, now in Senate Judiciary
HB 331	Lancione	Requires General Assembly to review certain agencies for their continued existence	Passed House, now in Senate Judiciary
HB 346	Tranter	Revises product liability statutes & establishes a statute of limitation based on useful life of product	Insurance, Utilities & Financial Institutions
HB 353	Hale	Establishes a council to set drug prices & create a list of drugs that are equivalent for substitution	Judiciary
HB 354	Hale	Provides for a reduction in amount of fluoride permitted in public water supplies by 1980	Governmental Affairs
HB 355	Hale	Requires study of venereal disease in grades 7-12	Health and Retirement
HB 378	O'Neill	Expands licensing program for residential care facilities for the mentally retarded to include developmentally disabled	Health and Retirement
HB 383	Begala	Makes Dept. of Public Welfare responsible for social services program under Title XX; appointment of County Welfare Advisory Board	Law, effective 8-15-77
HB 390	Galbraith	Designates the office of coroner as an appointive office	Governmental Affairs
HB 408	Rankin	Makes an $8 million supplemental appropriation to Welfare Department for emergency assistance for current fiscal year	Finance and Appropriations
HB 410	Fries	Expands Attorney General's anti-trust investigatory powers	Passed House and Senate
HB 413	Sweeney	Requires the Public Health Council to adopt rules probihiting discrimination by hospitals in staff membership and professional privileges	Passed House, now in Senate Education and Health
HB 443	McLin	Requires establishment of programs for residency training positions in primary care medical fields	Approved by Health & Retirement, rereferred to Finance and Appropriations
HB 490	Christman	Creates a Department of Health Finance and Planning	Rereferred to Finance and Appropriations
HB 516	Stinziano	Permits an individual to direct that no medical maintenance be administered if condition is terminal	Defeated in Health & Retirement Rereferred to Judiciary
HB 546	Carney	Changes the title "massage" to "manual therapy"	Governmental Affairs
HB 557	Wargo	Allows businesses to pay administrative costs of administering political check-offs for employees	Law, effective 11-18-77

Bill	Sponsor	Subject	Current Status
HB 592	Brown S	Permits use of saccharin	Approved by Commerce and Labor 6-8-77
HB 598	Skeen	Permits civil actions against employers who discriminate on the basis of age	Passed House, now in Senate Commerce and Labor
HB 600	Hartley	Establishes nursing home "patients' bill of rights"	Judiciary
HB 604	Hartley	Makes age discrimination illegal	Economic Affairs and Federal Relations
HB 650	Sweeney	Regulates use of laetrile	Passed House, now in Senate Education and Health
HB 674	McLin	Establishes College of Professional Psychology at Wright State	Education
HB 687	Batchelder	Mandates VD testing of pregnant women prior to delivery	Health and Retirement
HB 698	Locker	Licenses general and special counselors	Approved by Economic Affairs and Federal Relations
HB 704	Hale	Provides for licensing of adult foster care facilities	Passed House, now in Senate
HB 709	Orlett	Permits the use of heroin in experimental drug maintenance treatment programs	Passed House, now in Senate Judiciary
HB 710	Hale	Requires courses in family living be offered to grades 6-9	Education
HB 725	Leonard	Revises HB 244 (111th G.A.), mentally ill patients' rights	Passed House and Senate
HB 747	Kurfess	Revises lobbying accounting and reporting law	Introduced 6-7-77
HB 755	Lehman	Includes reciprocal medical malpractice insurer in JUA	Insurance, Utilities and Financial Institutions
HB 762	Camera	Extends unemployment benefits to new classes of employees	Passed House and Senate
HB 773	Hale	Establishes a state board to provide services to pregnant teenagers	Finance and Appropriations
HB 840	Rocco	Extends immunity from civil liability to certain medics	Governmental Affairs
HB 864	Eckart	Revises state health care planning procedures (Certificate of Need)	House Finance
HB 870	Hale	Provides for the licensing of residential care facilities for mentally ill persons	House Judiciary
HB 871	Orlett	Provides for diagnosis and treatment of mentally ill furloughees	House Judiciary
HB 887	Hartley	Repeals speech pathologists and audiologists licensure law	House Human Resources
HB 928	Fox	Requires interim payments under medical assistant's program other than nursing and rest homes	Introduced 9-28-77
HB 932	Branstool	Prohibits state reimbursements to medical providers who have been convicted of fraud against the state	House Judiciary
HB 958	Stinziano	Provides for treble damages against providers who defraud the state	Introduced 11-15-77
HJR 4	Jones	Memorializes Congress to fully fund Medicaid Program	Passed House, now in Senate Finance
HJR 33	Fox	Authorizes study of Federal Regionalism	Adopted by Economic Affairs & Federal Relations
HJR 35	Jones	Establishes a study commission to study rising hospital and medical costs	Senate Rules
HCR 14	Leonard	Disapproves the proposed Ohio rules of evidence	Adopted

BILLS INTRODUCED IN SENATE

SB 14	Freeman	Requires periodic review by legislature of continued existence of all state agencies	Judiciary
SB 23	Carney	Provides for registration of sanitarians and sanitarians in training	Conservation and Environment Postponed indefinitely
SB 31	Carney	Includes alcoholism coverage in sickness and accident insurance policies	Elections, Financial Institutions and Insurance Subcommittee
SB 36	Freeman	Requires the Depart. of Welfare to contract with 3rd party for paying medical assistance claims	Finance
SB 40	Valiquette	Requires additional officials to file financial disclosure statements	Law
SB 45	Freeman	Repeals anti-substitution drug laws	Law effective 1-1-78

Bill	Sponsor	Subject	Current Status
SB 71	McCormack	Expands licensing program for residential care facilities to include developmentally disabled persons	Law, effective 10-31-77
SB 90	Stano	Provides coverage for mental and emotional disorders and alcoholism in insurance plans	Passed Senate, now in House IUF
SB 91	Butts	Requires employers to grant paid time off for workman's compensation hearings	Passed Senate, now in House Commerce and Labor
SB 130	Jackson	Authorizes the administration of anesthetics by qualified persons under direction or in presence of licensed anesthesiologist	Passed Senate 7-23-77 Approved by House Judiciary
SB 134	Roberto	Permits Wright State U. & Northeastern Ohio U. Cols. of Medicine to use funds to improve property owned by hosp. corporations	Law, effective 5-6-77
SB 138	Mussey	Authorizes persons undergoing training for EMT-A and paramedics to ride in ambulances and emergency vehicles	Education and Health
SB 143	Aronoff	Clarifies and strengthens the 1975 privacy act	Judiciary
SB 157	Calabrese	Prohibits restraints on advertising cost of eyeglasses & requires copies of prescription be given to patient	Passed Senate, now in House Health & Retirement Com.
SB 159	Meshel	Empowers the attorney general to recover Medicaid overpayments	Approved by House Finance
SB 163	Jackson	Requires diagnostic pharmaceutical agent's license before optometrist may use diagnostic drugs & changes license of optometrists	Approved by Education and Health, now in Rules
SB 172	Bowen	Permits G.A. to invalidate state agency rules & establish joint legislative committee to review state agency rules	Ways and Means
SB 177	Maloney	Restricts the introduction of bills & requires standing committees to exercise legislative oversight during 112th G.A.	Ways and Means
SB 178	Maloney	Requires each General Assembly to set dates for the completion of its legislative business	Ways and Means
SB 202	Valiquette	Hospital patients' "bill of rights"	Passed Senate In House Reference Com.
SB 203	Valiquette	Makes privileged information of that acquired while providing counseling to sexual assault victims	Law, effective 1-13-78
SB 216	McCormack	Provides for control of lobbying	Judiciary
SB 221	Meshel	Companion bill to HB 191 (budget act), contains appropriation language	Law, effective 11-23-77
SB 224	Aronoff	Clarifies provisions of the privacy act	Law, 8-26-77
SB 233	Calabrese	Nursing home patients' "bill of rights"	Education and Health
SB 237	Meshel	Authorizes conditions for Welfare Dept. to make demonstration project grants aimed to encourage facilities for care of persons eligible for medical aid	Law, effective 11-21-77
SB 240	Bowen	Permits advertising for professional services	Commerce and Labor, approved
SB 253	Maloney	Extends insurance equity laws	Elections, Financial Institutions, & Insurance
SB 258	Roberto	Substitutes a form of comparative negligence for the common law doctrine of contributory negligence in determining recovery in negligence actions	Passed Senate, now in House Insurance, Utilities, and Financial Institutions
SB 272	Meshel	Establishes certain classes for determining rates for individual subscription contracts of hospital service associations	Elections, Financial Institutions and Insurance
SB 282	Celebrezze	Requires schools to maintain vaccination and immunization records	Passed Senate, now in House Education
SB 283	Valiquette	Congressional redistricting bill	Passed Senate, Passed House Governmental Affairs in House Rules
SB 285	Bowen	Licenses general and special counselors	Passed Senate, now in Rules
SB 294	Mahoney	Clarifies method for making anatomical gifts by statements on driver licenses or endorsements	Passed Senate, now in House Highway Safety
SB 299	O'Shaughnessy	Extends existence of the JUA for two years	Law, effective 11-24-77
SB 307	Van Meter	Requires gonorrhea test just prior to delivery	Education and Health
SB 314	Butts	Protects third party payor from civil liability suits	Judiciary
SB 315	McCormack	Transfers jurisdiction over the treatment and control of alcoholism from Depart. of Health to Depart. of Mental Health & Mental Retardation	Education and Health
SB 322	Carney	Liberalizes Ohio unemployment compensation laws	Commerce and Labor

Bill	Sponsor	Subject	Current Status
SB 328	Roberto	Establishes Ohio Optical Dispensers Bd. & requires licensing of optical aid dispensers	Education and Health
SB 331	Mahoney	Provides for licensing home health agencies by the Health Department	Education and Health Subcommittee
SB 347	Nabakowski	Extends immunity from civil liability to emergency medical technicians or paramedics in training	Education and Health
SB 349	Valiquette	Revises state health care planning procedures (Certificate of Need)	Senate Finance
SB 352	Meshel	Exempts volunteers of hospital and nursing homes from cosmetology licensing	Senate Commerce and Labor
SB 370	Celebrezze	Permits courts to award attorney's fees to winning party	Senate Judiciary
SB 373	Bowen	Revises furlough arrangements for mental patients	Senate Education and Health
SB 374	O'Shaughnessy	Prohibits persons convicted of theft when dealing with the state from engaging in business with the state for five years	Senate Ways & Means
SB 376	Freeman	Requires the Welfare Depart. to follow the Administrative Procedures Act	Senate Ways and Means
SB 377	Freeman	Abolishes mandatory retirement and age discrimination for public employees	Senate Commerce and Labor
SJR 17	Bowen	Allows attorneys to advertise	Senate Rules Committee

MEDICLINICS

POSTGRADUATE MEDICAL REFRESHER COURSE

FORT LAUDERDALE, FLORIDA

MARCH 6 - 17, 1978

SPONSORED BY FLORIDA ACADEMY OF FAMILY PRACTICE AND
THE BROWARD MEDICAL CENTER

"This program is acceptable for 50 (Prescribed Hours) by the
American Academy of Family Physicians."

PRE-REGISTRATION — $300.00

MEDICLINICS
832 Central Medical Building
Saint Paul. Minnesota 55104

**EXCELLENT FACULTY, FINEST HOTEL,
PEAK OF WINTER SEASON**

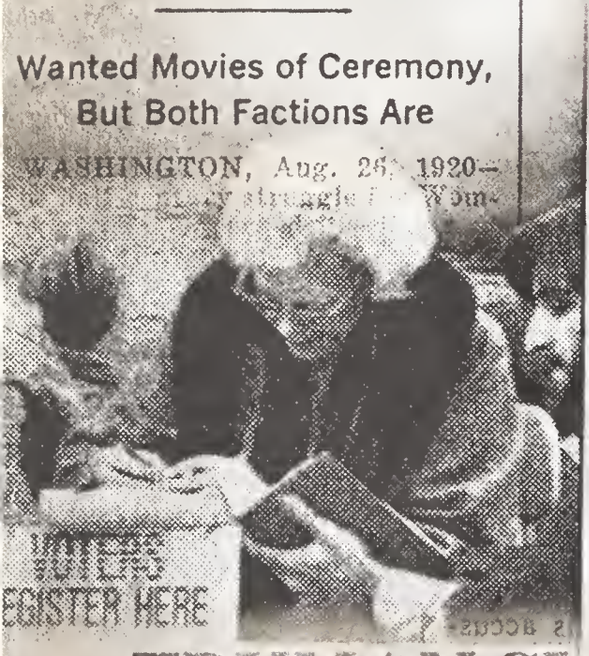
COLBY PROCLAIMS WOMAN SUFFRAGE

Signs Certificate of Ratification at His Home Without Women Witnesses.

MILITANTS VEXED AT PRIVACY.

Wanted Movies of Ceremony, But Both Factions Are

WASHINGTON, Aug. 26, 1920—



Social Security Bill Is Signed; Gives Pensions to Aged, Jobl

Roosevelt Approves Message Intended to Benefit 30,000, Persons When States Adopt Cooperating Laws-He Cal the Measure 'Cornerstone' of His Economic Program.

WASHINGTON, Aug. 14, 1
The Social Security Bill, provi
a broad program of unemploy
insurance and old age pens
and counted upon to benefit
20,000,000 persons, became la
day when it was signed by P
dent Roosevelt in the presen
those chiefly responsible for
ting it through Co
s.

Mr. Roosevelt cal
the mea
"the cor
erstone
stru
which is being
t
me
s c
mple
COM

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today, 94 to 0, and sent

TRUMAN CLOSES TED NATIONS CONFEREN ITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

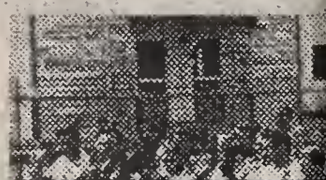
Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

SIGNE the Draf Ends Nov

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the



PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

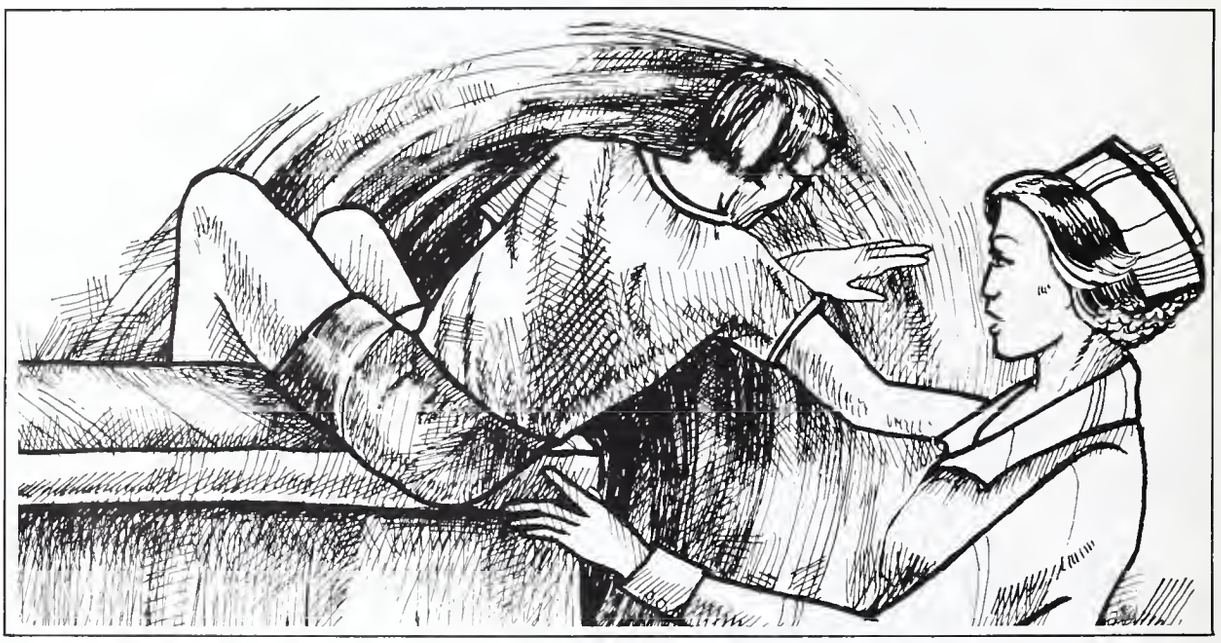
The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA
THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION
1155 FIFTEENTH ST. N. W. WASHINGTON, D. C. 20005

MEDICAL PREMISES LIABILITY?

MEDICAL PROFESSIONAL LIABILITY?



If these two coverages are split between two insurers, there may be disagreement or even litigation about which policy applies.

It need not happen to you. Go with PICO, the insurance company that provides superior plans for **both** coverages.

PICO's Professional Liability Policy AND Physician's Office Protection Policy.

Complete Insurance Protection for your Medical Practice

Physicians Insurance Company of Ohio
6100 Channingway Boulevard
Columbus, Ohio 43227
Telephone 614-864-3043

PICO

The Ohio State Medical Association Obituaries

JOHN M. BENKO, M.D., Youngstown; St. Louis University School of Medicine, 1934; age 70; died November 9, 1977; member OSMA and AMA.

THOMAS W. COOK, M.D., Cleveland; Case Western Reserve University School of Medicine, 1944; age 56; died October 25, 1977; member OSMA and AMA.

JAMES W. GERMAN, M.D., Cuyahoga Falls; Case Western Reserve University School of Medicine, 1936; age 68; died November 11, 1977; member OSMA and AMA.

WILLIAM HEPP, M.D., Cincinnati; University of Cincinnati College of Medicine, 1930; age 72; died November 2, 1977; member OSMA and AMA.

ROBERT B. JACOBS, M.D., Xenia; Ohio State University College of Medicine, 1938; age 68; died October 13, 1977; member OSMA and AMA.

HENRY W. KARRER, M.D., Dublin; Ohio State University College of Medicine, 1931; age 70; died October 28, 1977; member OSMA and AMA.

ROBERT A. LYON, M.D., Cincinnati; University of Cincinnati College of Medicine, 1925; age 77; died November 3, 1977; member OSMA and AMA.

WILLIAM MALLOY, M.D., Massillon; Meharry Medical College School of Medicine, Nashville, 1923; age 81; died October 26, 1977; member OSMA and AMA.

ALSTON MORRISON, M.D., Marion; University of Michigan Medical School, 1933; age 71; died November 7, 1977; member OSMA and AMA.

JOHN P. SAUVAGEOT, M.D., Akron; Ohio State University College of Medicine, 1928; age 74; died October 23, 1977; member OSMA and AMA.

ROGER K. SMITH, M.D., Akron; Ohio State University College of Medicine, 1968; age 35; died October 2, 1977; member OSMA and AMA.

HERBERT S. WELLS, M.D., Willoughby; Johns Hopkins University School of Medicine, Baltimore, 1924; age 79; died October 30, 1977; member OSMA and AMA.

ALBERT D. WEYMAN, M.D., Fort Myers, Florida; University of Cincinnati College of Medicine, 1939, age 65; died November 7, 1977; member OSMA and AMA.

KWOK KUEN WONG, M.D., Washington Court House; College of Medicine of National Taiwan University, Taipei, Formosa, 1966; age 39; died October 17, 1977; member OSMA and AMA.

PHILIP K. WOOD, M.D., Galena; Ohio State University School of Medicine, 1960; age 42; died November 1, 1977; member OSMA and AMA.

CHAUNCEY WYCKOFF, M.D., Chagrin Falls; Case Western Reserve University School of Medicine, 1908; age 95; died November 12, 1977; member OSMA and AMA.



THE WENDT-BRISTOL COMPANY
1159 DUBLIN ROAD
COLUMBUS, OHIO 43215
614/486-9411

MEDICAL/SURGICAL PRODUCTS
LABORATORY PRODUCTS
SPECIALTY PRODUCTS
PHARMACEUTICALS
PATIENT AIDS
INSTRUMENTS
FURNITURE

Ohio State Medical Association Proceedings of the Council

A regular meeting of the Council of the Ohio State Medical Association was held Saturday, November 19, 1977 at the OSMA Headquarters' Office, 600 South High Street, Columbus, Ohio.

ATTENDANCE

OSMA Council Present: William M. Wells, M.D., Newark, President; John J. Gaughan, M.D., Cleveland, President-Elect; Robert G. Thomas, M.D., Elyria, Secretary-Treasurer; Stewart B. Dunsker, M.D., Cincinnati, First District Councilor; W. J. Lewis, M.D., Dayton, Second District Councilor; Alford C. Diller, M.D., Convoy, Third District Councilor; C. Douglass Ford, M.D., Toledo, Fourth District Councilor; C. Edward Pichette, M.D., Youngstown, Sixth District Councilor; Richard E. Hartle, M.D., Lancaster, Eighth District Councilor; Thomas W. Morgan, M.D., Gallipolis, Ninth District Councilor; J. Hutchison Williams, M.D., Columbus, Tenth District Councilor; and William Dorner, Jr., M.D., Akron, Twelfth District Councilor.

Absent: George N. Bates, M.D., Toledo, Past President; Theodore J. Castele, M.D., Cleveland, Fifth District Councilor; Robert E. Rinderknecht, M.D., Dover, Seventh District Councilor; and S. Baird Pfahl, Jr., M.D., Sandusky, Eleventh District Councilor.

Guests Present: P. John Robechek, M.D., Cleveland, Chairman, Ohio Delegation to the AMA; John H. Ackerman, M.D., Columbus, Director, Ohio Department of Health; James E. Pohlman, Esq., Columbus, OSMA Legal Counsel; Mrs. Albert May, Marion, President, OSMA Auxiliary; and David L. Rader, Vice President/Administration, Physicians' Insurance Company of Ohio.

OSMA Staff Present: Hart F. Page, Charles W. Edgar, Herbert E. Gillen, Jerry J. Campbell, Robert D. Clinger, Katherine E. Wisse, D. Brent Mulgrew, Robert E. Holcomb, Gail E. Dodson, Rebecca J. Doll, David C. Torrens, and Judy Franklin.

ADMINISTRATION DEPARTMENT

The minutes of the September 10, 1977 meeting of the Council were approved.

President's Announcements

Dr. Wells announced that there would be a special meeting of the House of Delegates at 10 AM, December 18, 1977, Neil House Motor Hotel, Columbus, Ohio. The session was called in response to written requests of 23 county medical society presidents under the provisions of Article X, Section 3 of the Constitution of the Association. The subject of the session will be National Health Insurance.

Uniform Practice Plan

An article entitled "Uniform Practice Plan Underway for College of Medicine" from the November 1977 issue of *The Ohio State University Monthly* was distributed for information.

Travel

Travel plans for 1978 were approved as follows (all with INTRAV of St. Louis):

(1) SOUTH AMERICAN ADVENTURE — 9 days, February 18, Cleveland/Cincinnati departures; (2) RHINE RIVER ADVENTURE— 10 days, June 12, Columbus departure (with Michigan State Medical Society); (3) SCANDINAVIA ADVENTURE— 14 days, July 14, Cleveland/Cincinnati departures; (4) IMPERIAL EUROPEAN ADVENTURE— 10 days, August 14, Cleveland/Cincinnati departures; and (5) EASTERN MEDITERRANEAN— 14 days Air/Sea Cruise-Stella Solaris, October 20, Columbus departure (with Michigan State Medical Society).

The Council authorized the Executive Director to work with Bradford Travel Service on a proposed trip for Ohio physicians to the Peoples Republic of China.

The Council approved the inscription of a plaque honoring INTRAV and its President, Mr. Barney Ebsworth, "for extraordinary accomplishments on behalf of Ohio physicians and their families who were at San Salvador during the Guatemala earthquake of 1976."



LEFT TO RIGHT: Hart F. Page, C.A.E., OSMA Executive Director; William M. Wells, M.D., OSMA President; Oscar W. Clarke, M.D.; and Barney Ebsworth, President of INTRAV.

Formation of an Ohio Association of Professionals

In reply to a request for the formation of an Ohio Association of Professionals, it was the Council's conclusion that such an organization already exists in the form of the Ohio Professions Council.

FINANCIAL AND MEMBERSHIP DEPARTMENT

Membership statistics were presented by Mrs. Wisse and indicated a membership gain of 437 as of October 31, 1977.

Ad Hoc Committee on Creation of Resident Physicians Section

Dr. Williams presented a progress report of the Ad Hoc Committee assigned to the implementation of Resolution 3-77 (to create a Resident Physicians Section).

Committee on Auditing and Appropriations

The minutes of the November 18 meeting of the Committee on Auditing and Appropriations were presented by Dr. Thomas.

The Council **approved** the committee's recommendation for expenditures of $578 from the Malpractice Research Fund.

The purchase of a small tract of land contiguous to the Association building to the south (618-620 South High Street) was authorized.

A new data processing system was discussed and the Council voted to authorize the officers to make the final selection of software and hardware.

The report, as a whole, **was approved.**

Affiliate Membership

Under the provisions of Chapter 1, Section 2 (h) of the OSMA Bylaws, the following medical society executives **were approved** for affiliate membership in the Ohio State Medical Association: William J. Galligan and Edward W. Hoffman, Academy of Medicine of Cincinnati; Robert A. Lang, Ph.D., Academy of Medicine of Cleveland; James S. Imboden, Jean Armour, and Sylvia Henderson, Academy of Medicine of Columbus and Franklin County; Lee F. Wealton, Academy of Medicine, Toledo & Lucas County; Howard C. Rempes, Jr., Mahoning County Medical Society; Earl E. Shelton, Willadean L. Mitchell, and Richard G. Tapia, Montgomery County Medical Society; S. H. Mountcastle and Jan Armstrong, Summit County Medical Society; Florence Landis, Ohio Academy of Family Physicians; Hart F. Page, Charles W. Edgar, Gail E. Dodson, Herbert E. Gillen, Jerry J. Campbell, Robert D. Clinger, Katherine E. Wisse, Robert E. Holcomb, and D. Brent Mulgrew, Ohio State Medical Association.

AMA Dues Billing and Remittance

The Council **approved** proposed criteria for AMA dues billing and remittance which has been developed by the American Association of Medical Society Executives at the request of the AMA House of Delegates in June 1977. The nine criteria were developed and were approved by the AMA Board of Trustees for improving AMA billing and remittance procedures. Final action on the criteria will be taken at the December meeting of the AMA House of Delegates.

Also **approved** were uniform guidelines and procedures to be observed by the AMA, as well as recommended for increased membership recruitment efforts. Description of this triple document is attached to the minutes.

Unified Membership

The Council **approved** the minutes of a meeting of the Council, sitting as a Committee of the Whole, regarding "Unified Membership," held on October 29, 1977, as follows:

Dr. Wells asked the Council as a committee of the whole to study Resolution 8-77, regarding "Unified Membership."

Those present were all members of the Council except Drs. Bates, Dunsker, and Rinderknecht.

Dr. Lewis presented the arguments in favor of Ohio becoming a "unified state" with regard to medical federation membership. This would mandate all Ohio county and state medical association members to hold membership in the American Medical Association.

After the discussion, the Councilors decided to discuss with their county medical societies the possible effects of "Unified Membership" on membership and participation in the county organizations.

The Executive Director was instructed to seek information on what the experience has been when this procedure has been tried in other states.

It was voted to delay further consideration until the new billing criteria, being processed by the AMA and the American Association of Medical Society Executives at the request of the AMA House of Delegates, has been implemented and given a fair trial.

DEPARTMENT OF CONTINUING MEDICAL EDUCATION

Committee on Emergency and Disaster Medical Care

The minutes of the Committee on Emergency and Disaster Medical Care meeting of October 8, 1977 were presented by Mr. Torrens.

The Council **approved** OSMA's cosponsorship of a brochure on first-aid treatment for anhydrous ammonia burns contingent upon amendment of the title of the publication indicating that the subject involves first-aid treatment rather than medical treatment.

The Council asked Legal Counsel for an opinion on what legal ramifications arise when Ohio physicians, EMT-A's, and EMT-P's go into a neighboring state to render medical assistance and/or give medical advice by 'phone or telemetry.

The minutes were **approved** as amended.

OSMA Sections and Specialty Societies

A meeting of the OSMA Sections and Specialty Societies, October 12, was reported by Mrs. Dodson for information.

Committee on Education

The minutes of the Committee on Education meeting of October 20, 1977 were presented by Mrs. Dodson and **were approved.**

CME Requirements/Osteopathic Physicians

Problems involving osteopathic physicians and surgeons who are members of the OSMA and/or have obtained continuing medical education from other than osteopathic institutions as CME requirements for trien-

(Proceedings continued on page 52)

nial recertification were discussed. The matter was referred to Legal Counsel and the Joint Officers meeting on November 30, 1977.

GOVERNMENT MEDICAL CARE DEPARTMENT

Committee on Workmen's Compensation

The minutes of the Committee on Workmen's Compensation meeting of September 21, 1977 were presented by Mr. Gillen.

In connection with a recommendation from the committee, which would have encouraged the Bureau of Workers' Compensation to require coding of injuries according to the International Classification of Diseases with the provision that allowances be made for changing diagnosis, the Council asked that the decision be deferred until determination can be made as to the most universal method used by physicians.

The Council reaffirmed its previous position on "second opinions" (See *The Journal,* Vol. 73, No. 4, page 254, April 1977), and approved a recommendation that after a period of one year individuals on temporary total disability should be referred to the Ohio Rehabilitation Commission.

Three definitions involving the terms *temporary disability, temporary partial disability,* and *permanent total disability* were re-referred to the committee for clarification.

The Council authorized representation of the OSMA on the Peer Review Section of the Workers' Compensation System.

The minutes, as a whole, **were approved,** as amended.

Committee on Prisons and Jails

The minutes of the Committee on Prisons and Jails meeting of September 28, 1977 were presented by Mr. Gillen for information.

Conferences for Hospital Medical Staffs and Chiefs of Staff

Mr. Gillen reported on a Conference for Hospital Medical Staffs on September 30-October 1, and on a Conference for Chiefs of Staff, held on November 5 and 6, 1977.

Medical Advances Institute

Data with regard to the operation of Medical Advances Institute was presented to the Council for information.

Ohio Medical Indemnity, Inc.

Mr. Gillen reported on a meeting of the Board of Trustees of Ohio Medical Indemnity, Inc., held October 19, 1977.

Ohio Health Data Corporation

The minutes of a meeting of the Ohio Health Data Corporation on September 21, 1977 were reported for the information of the Council.

(Proceedings continued on page 54)



Cardilate® (erythrityl tetranitrate)
INDICATIONS: For the prophylaxis and long-terr treatment of patients with frequent or recurrent anginal pain and reduced exercise tolerance associated with angina pectoris, rather than for the treatment of the acute attack of angina pectori since its onset is somewhat slower than that of nitroglycerin

PRECAUTIONS: As with other effective nitrites, some fall in blood pressure may occur with large doses

Caution should be observed in administering the drug to patients with a history of recent cerebral hemorrhage, because of the vasodilation which occurs in the area. Although therapy permits more normal activity, the patient should not be allowed to misinterpret freedom from anginal attacks as a signal to drop all restrictions

SIDE EFFECTS: No serious side effects have been reported. In sublingual therapy, a tingling sensation (like that of nitroglycerin) may sometimes be noted at the point of tablet contact with the mucous membrane. If objectionable, this may be mitigated by placing the tablet in the buccal pouch. As with nitroglycerin or other effective nitrites, temporary vascular headache may occur during the first few days of therapy. This can be controlled by temporary dosage reduction in order to allow adjustment of the cerebral hemodynamics to the initial marked cerebral vasodilation. These headaches usually disappear within one week of continuous therapy but may be minimized by the administration of analgesics

Mild gastrointestinal disturbances occur occasionally with larger doses and may be controlled by reducing the dose temporarily

HOW SUPPLIED: 10 mg chewable scored tablets, bottle of 100. Also 5, 10 and 15 mg oral/sublingual scored tablets in bottles of 100. 10 mg oral/sublingual scored tablets also supplied in bottles of 1,000

Also available: Cardilate®-P brand Erythrityl Tetranitrate with Phenobarbital* Tablets (Scored).

(*Warning—may be habit-forming.)

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709



"**Our sex life is nil...**" A problem of the first magnitude to many post infarct patients and their mates...patients are often reluctant to broach the subject; physicians may frequently overlook its implications. This new 16mm film combines candid patient interviews with discussions by Drs. Herman Hellerstein, Thomas Hackett, Albert Kattus, Richard Stein, Carroll Witten and Lenore Zohman. Film and related monograph comprise 2 AAFP credit hours. To arrange viewing, write Burroughs Wellcome Co., Educational Services Department, Research Triangle Park, N.C. 27709 or contact your B.W. Co.® representative.

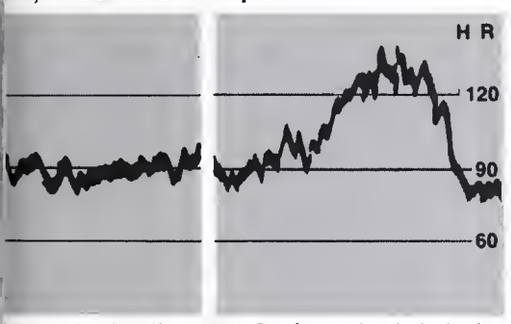
Sex and the heart patient:

A film every doctor should see.

he energy cost of sex to the eart is relatively modest.

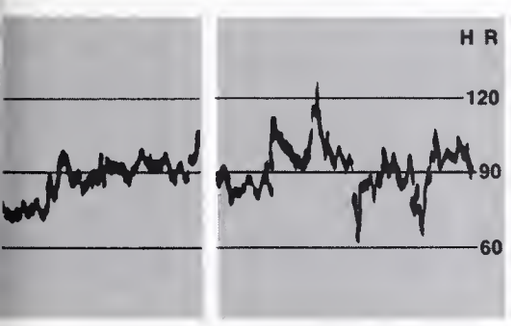
)ver 80% of post-coronary patients an ultimately resume sexual activity vithout serious risk. Hellerstein and reedman demonstrate that mean naximal heart rate during orgasm vith spouse (as opposed to extra-narital sex) in 14 post-infarct pa-ents is lower than that during usual)ccupational activity.

Representations below of actual EKG readings of an attorney, post MI, illustrate the point:



A. Working in office (about 90 beats/min)

B. Confrontation in judge's chamber (about 125 beats/min)



C. Pre-orgasm sex activity (about 90 beats/min)

D. Peaks at orgasm (120 beats/min)



Fear of pain greatest deterrent to post MI sex

In the multitude of MI patients with angina, pain is due to diminished coronary reserve and increased myocardial oxygen demand, precipitated by sex, other excitement and improper exercise. Anginal pain, however, can be relieved, and its recurrence mitigated.

Cardilate® (erythrityl tetranitrate) increases exercise tolerance.

Cardilate relieves anginal pain and prevents its recurrence, thereby allowing increased activity.

Commencing to work in as little as 2 to 5 minutes, Cardilate protects against recurrence of angina for at least 2 hours.

Available in both sublingual and chewable forms, Cardilate is a versatile, convenient agent to help make the angina patient's life more livable.

Cardilate®

(erythrityl tetranitrate)

Proceedings of the Council

Dr. Diller and Dr. Hartle were designated as members of the Board of Trustees from the OSMA.

United Auto Workers' Vision Care Program

The Council authorized representatives to a seminar on the United Auto Workers' Vision Care Program, to be held December 14, 1977 in Columbus, Ohio.

"National Guidelines for Health Planning"

The Council **approved** a letter with regard to the proposed "National Guidelines for Health Planning," which was published in the *Federal Register* September 23, 1977 and authorized that it be forwarded to the Office of Planning, Evaluation and Legislation of the Health Resources Administration.

DEPARTMENT OF ORGANIZATION SERVICES

Task Force on Professional Liability

The minutes of the Task Force on Professional Liability meeting on October 12, 1977 were presented by Mr. Campbell.

The Council **approved** the recommendations of the Task Force regarding an OSMA-Jeppesen-Sanderson contract under the MED PREP Program. Also accepted were recommendations concerning the participation of county medical societies in the program and the cost of the program to OSMA members.

The Council accepted the Task Force recommendations with regard to continued implementation of the countersuit program.

Recommendations of the Task Force concerning Substitute Resolution No. 30-77, Amended Resolution No. 34-77, Amended Resolution No. 49-77 and Resolutions Nos. 42-77 and 51-77 were accepted.

The minutes of the Task Force on Professional Liability, as a whole, **were approved.**

American Medical Association

Dr. Robechek and Mr. Campbell reported on arrangements for the interim session of the AMA House of Delegates in Chicago, December 4-7, 1977.

The Council studied and discussed a letter dated November 15, 1977, from John H. Budd, M.D., concerning Report A of the Council on Long Range Planning and Development and Report E of the AMA Board of Trustees, with regard to specialty society representation in the AMA. The Long Range Planning report would, in effect, phase out the sections' representation and provide in lieu thereof for representation one delegate each from 48 specialty societies. This compromise would result in a House of Delegates of 269 members, approximately 80 percent of whom would be state medical society delegates. Under the recommendation, future specialty societies could be added upon recommendation of the Board of Trustees and the approval of the House. Terms of the delegates would be for two years.

After study of both Dr. Budd's letter and the report, and subsequent discussion, the Council voted to **approve** this modification in House of Delegates representation.

The Council voted to support the candidacy of Oscar W. Clarke, M.D., Gallipolis, a Past President of the OSMA and Vice-Chairman of the Ohio Delegation to the AMA, for a position on the Council on Medical Service of the AMA.

PICO

Mr. Rader reported $12 million in gross premium revenues and $8½ million in stock sales by Physicians Insurance Company of Ohio as of October 31, 1977.

Mr. Page distributed a memorandum to the Council indicating the number of PICO policyholders in each county.

DEPARTMENT OF HEALTH EDUCATION

Committee on School Health

The minutes of the Committee on School Health meeting on September 14, 1977 were presented by Mr. Clinger.

The Council endorsed the committee's recommendation that approval in concept be given to financial support through OMERF for the Health and Human Affairs Conferences for Ohio's elementary and secondary health education teachers. Pending that capability, a proposal for contributing funds for three such conferences in early 1978 will be submitted for consideration of the Auditing and Appropriations Committee and the OSMA Council.

The minutes of the Committee on School Health, as a whole, **were approved.**

Joint Advisory Committee on Special Education

The minutes of the Joint Advisory Committee on Special Education meeting on September 14, 1977 were presented by Mr. Clinger for information.

Committee on Health Manpower

The minutes of the Committee on Health Manpower meeting on September 21, 1977 were presented by Mr. Clinger for information.

Joint Advisory Committee on Sports Medicine

The minutes of the Joint Advisory Committee on Sports Medicine meeting on November 2, 1977 were presented by Mr. Clinger.

Consideration of the committee's recommendation to support the banning of the kickoff play in football competition through Grade 9 was deferred until more statistics are presented.

A recommendation for endorsing the certification of scholastic athletic trainers in Ohio high schools **was approved.**

The report of the committee, as a whole, **was approved.**

Committee on Mental Health

The minutes of the Committee on Mental Health meeting on November 13, 1977 were presented by Mr. Clinger.

Council discussed the committee's recommendation "that the Ohio State Medical Association oppose discrimination by any insurance company against persons

(Proceedings continued on page 56)

There is a better way to do it... You can find it!

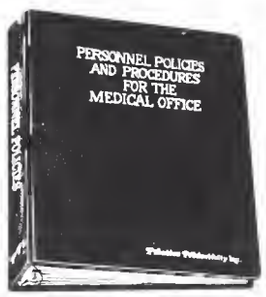
Two New Books Now Available -

PERSONNEL POLICIES AND PROCEDURES FOR THE MEDICAL OFFICE

Do you have personnel policies? Are they written? Are they up to date? Do they provide a clear, concise, competitive statement of what you offer and what you expect from your employees? Are your policies within the guidelines of recent legislation?

- Tells the employee what to expect on these important topics:

Working hours	Personal appearance	Vacation	Outside employment
Holidays	Personal phone calls	Housekeeping	Personal medical care
Smoking	Civic responsibilities	Parking	Compassionate leave



- Reviews policy topics for the manager in depth.
- Prewords sample policies for you on 23 topics.
- Makes you aware of many employer obligations such as:

Sick leave	Medical &	Salary	Summary dismissal
Personal days	dental appointments	Discipline	Other benefits
Probation	Performance review	Termination	Leave of absence

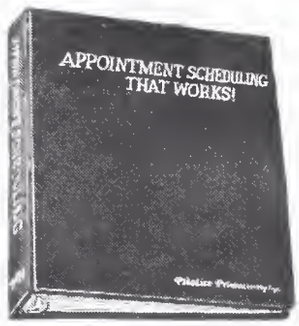
AN EASY WAY TO WRITE PERSONNEL POLICIES!

*

APPOINTMENT SCHEDULING THAT WORKS!

A course in appointment scheduling that enables your medical assistant to rebuild your scheduling system – according to the way you work.

- Your appointment employee learns about your real problems as she explores the improvements.
- The resulting schedule is custom designed for your specialty – the way you do things.
- Respects the patient's time. Keeps him from waiting more time than is reasonable - (usually 20 - 30 minutes maximum).
- Begin getting home on time.
- The workbook becomes a portfolio for continued improvement in future years.
- A simplified "Systems Analysis" approach to an age old problem.



A NEW APPOINTMENT SCHEDULE FOR YOU!

Practice Productivity Inc. **Management Consultants to Physicians**

Please send:

_____ copies of Personnel Policies and Procedures For the Medical Office at $24.50 + $1.80 for shipping and handling:Total $26.30.

_____ copies of Appointment Scheduling That Works! at $14.95 + $1.60 for shipping and handling: Total $16.55.

Send to:

Name _____ Telephone ( ) _____

Practice Name _____ Specialty _____

Address _____ No. of Doctors _____

City _____ State _____ Zip _____ No. of Employees _____

Bank Americard or Master Charge No. _____ Expiration Date ____/____Signature _____

Allow 2 - 3 weeks for delivery. Make check payable and send to:

PRACTICE PRODUCTIVITY INC., 2000 Clearview Avenue, Atlanta, Georgia 30340 (404) 455-7344

with any disease — including mental or emotional disorders and alcoholism. . . ." The Council decided that this recommendation needs further study, as well as consultation with insurance actuaries.

The Council also voted reaffirmation of its April 17, 1977 affirmation that physicians participate actively on the "648 boards" in Ohio (Community Mental Health Boards).

The minutes, as a whole, **were approved.**

DEPARTMENT OF FEDERAL LEGISLATION & PUBLIC POLICY

A report on the Department of Federal Legislation & Public Policy was given by its Director, Mr. Edgar.

The Council studied H.R. 3167, to mandate that 30 percent of PSRO board membership be nurses. Active opposition was voted.

The Executive Director relayed a message from Ken U. Benjamin, Jr., Assistant Director, Department of Congressional Relations, AMA Washington Office, thanking the Council for the establishment of the OSMA Department of Federal Legislation and expressing appreciation for the fine work of Mr. Edgar in assisting with medicine's legislative program on the federal level.

DEPARTMENT OF STATE LEGISLATION

Mr. Mulgrew reported on the approval of H.B. 725 in the Senate, a bill backed by the OSMA and the Ohio Hospital Association, to provide procedural changes to ease the burden on physicians engaged in mental health commitment procedures.

He reviewed the following bills: S.B. 349, certificate of need; H.B. 490, Health Department reorganization; S.B. 130, anesthesia assistant's bill; and others.

He announced that S.B. 163, to permit optometrists to use "diagnostic drugs" is still in the Senate Rules Committee.

He proposed a plan for development of state key legislative contacts among physicians in each House and Senate district, and the program **was approved** by Council.

COMMUNICATIONS DEPARTMENT

Ms. Doll reported on a Communications Seminar held in Columbus, on November 5, 1977, and presented minutes of the November 5 meeting of the Committee on Public Relations.

The committee's recommendations for public relations seminars open to all members during the ensuing year; establishing a library to assist speakers; a compilation of sample patient questionnaires, and the development of a prototype physicians' directory for use by county societies, **were approved** by the Council

The minutes of the meeting, as a whole, **were approved.**

FIELD SERVICE DEPARTMENT

Mr. Holcomb reviewed the County Medical Society Executives Day, held September 22, at the Headquarters' office in Columbus.

CONSTITUTION AND BYLAWS

The Articles of Incorporation of the Stark County Medical Society **were approved.**

LEGAL COUNSEL REPORT

Bauer vs. Medical Protective

The Council received information on a suit pending in the U.S. Sixth Circuit Court of Appeals, Bauer vs. Medical Protective. The Council decided not to enter this case as a friend of the Court, since the issues raised do not sufficiently involve the entire medical profession.

Resolution on Prior Policy Statements

The Council adopted the following resolution with regard to the present edition of *Opinions and Reports of the Judicial Council of the American Medical Association* and the withdrawal of prior policy positions of the Ohio State Medical Association:

> WHEREAS, the Judicial Council of the American Medical Association has earlier this year published a comprehensive revision of its Opinions and Reports and,
>
> WHEREAS, the present edition of its Opinions and Reports (1977) contains, among other matters, editorial changes, elimination of inconsistencies, withdrawal of items not adequately reflecting the current conditions of medical practice or legal requirements, and
>
> WHEREAS, this Council has in the past published guidelines for individual members and component county medical societies with regard to the principles of medical ethics which might be construed to be inconsistent with the 1977 publication of the Opinions and Reports of the Judicial Council, and
>
> WHEREAS, it is the desire of Council of the Ohio State Medical Association to update its statements of policy and guidelines to physicians to fairly and adequately reflect current conditions of medical practice and legal requirements,
>
> NOW THEREFORE BE IT RESOLVED that the Council of the Ohio State Medical Association hereby adopts the Opinions and Reports of the AMA Judicial Council (1977) and hereby withdraws all prior policy statements, position papers and publications of the Council of the Ohio State Medical Association which are contrary to or inconsistent with said Opinions and Reports.
>
> AND BE IT FURTHER RESOLVED that the staff of the Ohio State Medical Association be instructed to furnish copies of this resolution and a copy of the Opinions and Reports of the Judicial Council (1977) to each component county medical society.

West Shore Medical Complex

A problem of the West Shore Medical Complex of Cleveland was reviewed by Dr. Gaughan. The President was given authority to act upon a request from the Academy of Medicine of Cleveland and to refer the matter directly and promptly to the AMA.

Ohio State Medical Board

The Council discussed allegations that Ohio State Medical Board employees were electronically recording their conversations with physicians during investigations without the knowledge or consent of the physicians. Dr. Wells was asked to discuss the matter with Dr. Henry A. Crawford, President of the Board, to determine the Board policy on this practice.

AUXILIARY PRESIDENT

Mrs. Ingrid May, President of the OSMA Auxiliary, reported to the Council on the work of the Auxiliary.

She indicated that there was a membership of 4,955 state members as of July 1977, with 52 organized counties grouped into 12 districts. She stated that the Auxiliary is working diligently on membership recruitment.

She discussed the work of the Auxiliary in the areas of community services, health education, legislation, AMA-ERF, and International Health, and said that the goal for AMA-ERF for the coming year is $100,000.

OHIO DIRECTOR OF HEALTH

John H. Ackerman, M.D., Ohio Director of Health, was present and reported on current developments in public health.

ATTEST: Hart F. Page
Executive Director



Singalongs, German Band, Cocktails and Keg Beer. All meats, desserts, and soups are made right here in Schmidt's immaculate kitchens. Ask to see. Buy Bratwurst and Bahama Mamas to take home. 4 blocks East of S. High St. on Kossuth, just a few blocks from your medical association headquarters.

Fantastic new private party and meeting rooms serving German Buffet or any size sizzling Top Grade steak dinners. Reservations taken for parties 35 and up. Call 444-5050.

Liveliest Spot In German Village

Noon and Night



The All-Important Goal...

proper insurance protection for yourself — and family.

How to make that goal? Take direct aim on these excellent insurance plans sponsored by the OSMA. As the administrator, we'll be happy to help.

1. Disability Income Protection — The coverage that assures you a weekly income when you're disabled by an accident or illness. Select benefits up to $500 weekly.

2. Term Life Insurance — Quality life insurance with maximum coverage of $100,000. Membership or corporate plan available. A 43% dividend was paid last year. (Dividends are not guaranteed.)

We're happy to be on your team! For more information, contact:

TURNER SHEPARD INC.

17 South High Street Columbus, Ohio 43215 Phone (614) 228-6115
4015 Executive Park Drive Cincinnati, Ohio 45241 Phone (513) 563-4220
1900 Euclid Avenue Cleveland, Ohio 44115 Phone (216) 771-4747
3450 West Central Avenue Toledo, Ohio 43606 Phone (419) 535-0616

Colleagues in the News

JAMES C. GOOD, M.D., Columbus, has been promoted to the rank of Brigadier General, Medical Corps, Ohio Army National Guard. A family physician, Dr. Good is believed to be the first Ohio physician to achieve this rank in the Ohio National Guard. As Commander of the 112th Medical Brigade, he has medical service responsibility for all Army Guard troops in Ohio and certain training, logistics, and administrative involvement with the Army Guard medics of 12 other states comprising the United States Fifth Army.

AUSTIN H. KUSTER, M.D., is the new Chairman of the Department of Radiology of Akron City Hospital. Prior to this appointment, he was Chief of Diagnostic Radiology. **ROBERT H. HAMOR, M.D.,** Program Director of the Radiology Residency Training Program at the hospital, has assumed the duties of Chief of Diagnostic Radiology.

CHARLES MALONE, M.D., Cleveland, has been elected to a three-year term on the Board of the American Association of Psychiatric Services for Children (AAPSC). Dr. Malone is Director and Chief Psychiatrist of the Case Western Reserve University School of Medicine. The AAPSC is the only multidisciplinary group of child mental health agencies and professionals in the United States.

CARL A. MINNING, M.D., Batavia, has been selected 1977 GP of the Year by the American Academy of Family Physicians. Dr. Minning received the Tom Rardin Memorial Award in honor of his selection.

THOMAS W. MORGAN, M.D., Gallipolis, was recently honored by the Southeastern Ohio Regional Council as one of 11 outstanding men of southeastern Ohio. Among the honorees were physicians, industrialists, teachers, and community leaders representing 10 counties in southeastern Ohio. The awards are presented annually for outstanding achievements through participation and leadership in community affairs. Dr. Morgan serves as the OSMA Councilor of the Ninth District.

PENN G. SKILLERN, M.D., Cleveland, has been elected to a three-year term on the board of the American Group Practice Association. Dr. Skillern is a member of The Cleveland Clinic Foundation staff. Continuing as a Trustee with his term expiring in 1978 is **JAMES M. ORR, M.D.,** of the Holzer Medical Center Clinic in Gallipolis.

JOSEPH SCHULTZ, M.D., is the president of the Executive Council of the Cleveland Society of Obstetricians and Gynecologists. Other officers for the 1977-1978 term are **LAWRENCE ELLICK, M.D.,** president-elect; **JAMES A. BOWMAN, JR., M.D.,** secretary; **JAMES M. SHAW, M.D.,** assistant secretary; **DONALD HUBBELL, M.D.,** assistant treasurer; and **JOSEPH MARTIN, M.D.,** and **K. W. KENNEDY, M.D.,** members-at-large.

ROBERT J. WHITE, M.D., Ph.D., Cleveland, has been named President-Elect of the Society of University Neurosurgeons. President-Elect of the Academy of Medicine of Cleveland, Dr. White is Professor and Co-chairman of the Department of Neurosurgery at Case Western Reserve University School of Medicine and Director of Neurosurgery at Cleveland Metropolitan General Hospital.



The Tuscarawas County Medical Society and Bar Association cohosted John H. Budd, M.D., President of the AMA, and Mrs. Budd at a recent dinner. Pictured left to right: Mark Frasure, President of the Tuscarawas County Bar Association, and Mrs. Frasure; John J. Gaughan, M.D., OSMA President-Elect, and Mrs. Gaughan; Robert E. Rinderknecht, M.D., OSMA 7th District Councilor, and Mrs. Rinderknecht; Dr. and Mrs. Budd; Thomas W. Morgan, M.D., OSMA 9th District Councilor, and Mrs. Morgan; and Kenneth Van Epps, M.D., President of the Tuscarawas County Medical Society, and Mrs. Van Epps. (Photo courtesy *The Times-Reporter,* New Philadelphia, Ohio.)

Make Your Hotel Reservations

for the

1978 OSMA Annual Meeting

DAYTON, OHIO MAY 6-10

STOUFFER'S DAYTON PLAZA HOTEL ..... **5th and Jefferson Streets**
(OSMA Headquarters)

Single $27
Double $32

SHERATON DAYTON DOWNTOWN ..... **21 S. Jefferson Street**
(OSMA Co-Headquarters)

Single $24
Double $30

RAMADA INN / Downtown ..... **330 W. First Street**
(Auxiliary Headquarters)

Single $20
Double $25

HOLIDAY INN / Downtown ..... **404 W. First Street**

Single $23
Double $31

All rates subject to change. If you plan to share a room, please indicate name of roommate.

HOTEL RESERVATION BLANK
(Mail to Hotel of Choice)

_____
(Name of Hotel)

_____ Dayton, Ohio
(Address)

Please reserve the following accommodations during the period of the Ohio State Medical Association Annual Meeting, May 6-10, 1978 (or for period indicated). (Note: In order to accommodate you, please make reservations by April 15, 1978.)

_____ Single Room
_____ Double Room
_____ Other Accommodations

Price Range _____ Guaranteed _____

No. of Persons _____ Arrival Date _____ Hour of Arrival _____ Departure Date _____

Name _____

Address _____

City _____ State _____ Zip _____

PLEASE VERIFY MY RESERVATION

If Rate or Accommodation requested not available, next highest rate or accommodation will prevail.
Rooms will be held until 6 PM unless payment is guaranteed.


Kefzol® I.M./I.V.
cefazolin sodium
Ampoules, equivalent to 500 mg., 1 Gm.,
and 10 Gm. of cefazolin
NDC 0002-7014-01
AMPOULE No. 7014
Lilly
KEFZOL®
STERILE
CEFAZOLIN
SODIUM
Equivalent to
10 Gm.
Cefazolin
Protect from Light
PHARMACY
BULK PACKAGE
KEFZOL®
SODIUM
500 mg.
KEFZOL®
SODIUM
1 Gm.
Lilly
Additional information available
to the profession on request.
Eli Lilly and Company
Indianapolis, Indiana 46206
700773

News *(continued from page 36)*

Please contact the Ashland County Sheriff's Office, Ashland, Ohio, phone: 419/289-3911; or the BCI Headquarters, London, Ohio, phone 614/466-8204 with any information.

PICO Announces Sale of Excess Over Policies of Other Companies

The Physicians Insurance Company of Ohio has announced that effective January 1, 1978, OSMA members may purchase a PICO $1 million excess policy over a $200,000/$600,000 primary professional liability policy of certain other companies. OSMA members currently carrying primary coverage in this amount with such companies as Medical Protective, Hartford, U.S. F. & G., and Aetna may now purchase a PICO "occurrence" excess policy. PICO requires that each physician purchasing this excess policy over primary policies issued by other companies also hold one share of PICO stock.

Bureau of Workers' Compensation Requires Certain Information

Michael G. Gillig, Bureau of Workers' Compensation

Did you ever feel you were in the dark when it came to workers' compensation claims? Are you aware of various changes in Ohio's workers' compensation laws?

Ohio law now requires that all drug fee bills contain the following information about each prescription drug: (1) prescription number; (2) the name and type of drug or other remedy prescribed; (3) volume or quantity dispensed; (4) units and dosage of the drug prescribed; (5) designation of injury, occupational disease, or disability to which the medication is directly related; and (6) the name of the prescribing physician.

Therefore, physicians should place on each prescription the designation of injury, occupational disease, or disability to which the medication is directly related. If you have questions about the allowances of any claims, you should call the Bureau of Workers' Compensation's physicians' services number: 614/466-3652. This number has been set aside solely for use by physicians with questions concerning the disabilities for which the Bureau is authorized to make payment. If you fail to put the disability designation on a prescription, the pharmacist will have to contact you to get this information so that the drug fee bill can be completed.

In some instances, you might prescribe a drug for its secondary indication and the Bureau might require a further explanation. For example, unless you inform the Bureau that you are prescribing a nonsteroid, anti-inflammatory drug such as Butazolidin® for a secondary indication, the Bureau would think that you were treating an arthritic condition which may not be allowed. So that the Bureau will not have to interrupt you at a future date in such instances, you should explain on the prescription the exact use of the drug and the part of the body that is being treated. The pharmacist who fills the prescription can then put this explanation on his drug fee bill.

To shed some light on payment procedures, the Bureau has available at no charge the new *Medical Guidelines*. This publication is designed to assist health care providers in submitting workers' compensation claims and in getting paid in a timely manner. You can get your copy by merely sending a request to the Bureau.

Also available to assist is the Bureau's Inquiry and Response Section which has been upgraded and greatly expanded during the past few months. It has grown from subsection to full-section status, and there has been a 450 percent increase in personnel. With this growth, the emphasis has been placed on the "response" aspects of the job.

If you have any questions, do not hesitate to call the section's new telephone number: 614/466-1000. If your question concerns a fee bill, send a written inquiry to the Bureau and mark it for the attention of "Inquiries." *Medical Guidelines* contains a suggested inquiry form.

Medical Guidelines should provide a great deal of information on workers' compensation. If further information is needed on particular claims, help is as near as your phone— 614/466-1000 for general inquiries and 614/466-3652 for allowances of any claim.

Private Sector Begins Developing Voluntary Cost-Containment Plan

In a joint announcement, the American Medical Association, the American Hospital Association, and the Federation of American Hospitals listed those persons appointed to a national steering committee to develop a voluntary hospital-and-health-care-cost-containment program. In November 1977, the private sector announced its intentions to accept House Ways and Means Health Subcommittee Chairman Representative Dan Rostenkowski's (D-Illinois) challenge to develop a voluntary cost containment plan. Since then, the three associations have alerted hospitals and physicians nationwide of their commitment to seeking full participation in order to insure success.

In announcing the committee, President Alex McMahon of the American Hospital Association, Executive Director Michael D. Bromberg of the Federation of American Hospitals, and Executive Vice-President James H. Sammons, M.D., of the American Medical Association, issued this statement:

> This committee represents a broad spectrum of people including hospital administrators, doctors, insurers, business leaders and consumers. It is not a closed committee— others

(continued on page 65)

THE LOWER G.I. TRACT:
ORGANICALLY SOUND



Celiac angiography is one of a number of highly specialized diagnostic techniques sometimes necessary to rule out organic causes of abdominal pain.

...BUT OVERSENSITIVE TO EMOTIONAL STRESS



IN IRRITABLE BOWEL SYNDROME* LIBRAX PROVIDES DISTINCTIVE ADVANTAGES

- the specific antianxiety action of Librium®(chlordiazepoxide HCl)
- the potent antispasmodic action of Quarzan®(clidinium Br)

Adjunctive/Dual-Action

LIBRAX®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

A clear treatment advantage for patients with irritable bowel syndrome

ROCHE

*This drug has been evaluated as possibly effective for this indication.
Please see following page for brief summary of prescribing information.

A CLEAR TREATMENT ADVANTAGE FOR PATIENTS WITH IRRITABLE BOWEL SYNDROME*



Adjunctive/Dual-Action
LIBRAX®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

ONLY LIBRAX PROVIDES THE SPECIFIC ANTIANXIETY ACTION OF LIBRIUM® (chlordiazepoxide HCl) PLUS THE POTENT ANTISPASMODIC ACTION OF QUARZAN® (clidinium Br)

Please consult complete prescribing information, a summary of which follows:

* **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium® (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacologic effects of agents, particularly potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are avoidable in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of the mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

Dosage: Individualize for maximum beneficial effects. Usual maintenance dose is 1 or 2 capsules, 3 or 4 times a day, before meals and at bedtime. Geriatric patients—see Precautions.

How Supplied: Librax is available in green capsules, each containing 5 mg chlordiazepoxide hydrochloride (Librium®) and 2.5 mg clidinium bromide (Quarzan®)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50, available singly and in trays of 10.

ROCHE
Roche Products Inc.
Manati, Puerto Rico 00701

News *(continued from page 61)*

will be consulted on various questions. Hopefully, initial guidelines or screens to implement the national program will be promulgated at the conclusion of the (initial meeting in December 1977).

We reaffirm our position that voluntary restraint by hospitals is the most equitable method to achieve effective cost containment consistent with sound medical practice and with the least disruption to patient care.

Named to the committee were Samuel Tibbitts, Chairman-Elect of the American Hospital Association; Andrew W. Miller, President-Elect of the Federation of American Hospitals; Robert B. Hunter, M.D., Chairman of the Board of Trustees of the AMA; Robert Froehlke, President of the Health Insurance Association of America; Harold Buzzell, President of the Health Industry Manufacturers Association; Walter McNerney, President of the Blue Cross Association; Virginia Knauer, former Presidential Special Assistant on Consumer Affairs; and C. S. Tsorvas, General Electric Corporation's Consultant for Insurance Plans and Corporate Employee Relations and representative of the U.S. Chamber of Commerce.

Ohio Academy of Medical History Issues Call for Papers

The Ohio Academy of Medical History will hold its 1978 annual meeting at the Howard Dittrick Museum of Historical Medicine, Cleveland, on April 29, 1978. Abstracts of papers submitted for presentation should be sent to Patsy A. Gerstner, Secretary, Ohio Academy of Medical History, 11000 Euclid Avenue, Cleveland, Ohio 44106.

Occupational Illness Form Available From Dept. of Health

The Ohio Department of Health has available a "Certificate of Industrial or Occupational Disease." The purpose of the certificate is to alert the Director of Health, John Ackerman, M.D., of suspected or confirmed cases of occupational illnesses. A benefit to the reporting private physician is that Ohio Department of Health medical and industrial hygiene personnel will be used to discover and eliminate the source of the occupational illness. This service is funded through general state revenues. Physicians should contact the Ohio Department of Health for further information.

Burroughs Wellcome Company Offers Seminars Approved for Category I Education Credit

The AMA Liaison Committee on Continuing Medical Education has granted Burroughs Wellcome Company the right to offer continuing medical education (CME) seminars approved for Category I CME credit. A consistent advertiser in *The Journal,* the company is the first drug manufacturer to be given such accreditation. During 1976, Burroughs Wellcome Company sponsored 100 medical and scientific seminars for physicians and paramedical personnel at its Research Triangle Park, North Carolina headquarters. For further information, physicians may contact Stanley Grosshandler, M.D., Director of Continuing Medical Education, Burroughs Wellcome Co., 3030 Cornwallis Road, Research Triangle Park, North Carolina 27709, phone: 919/549-8371.

Cincinnati Enquirer Reporter Given Science Writing Fellowship

Health and medical reporter for *The Cincinnati Enquirer,* Barbara Redding, has been awarded the 1977 Ray Bruner Science Writing Fellowship by the American Public Health Association. Established in 1971 to encourage the development of young medical and health journalists, the award commemorates the 48-year career of the late science editor of *The Toledo Blade.* The fellowship, sponsored by Lederle Laboratories, is awarded annually to a reporter with less than two years' experience covering the health beat and less than five years' working experience as a journalist.



LEFT TO RIGHT: George E. Pickett, M.D., President of the American Public Health Association; Ms. Barbara Redding; and Robert P. Luciano, President of Lederle Laboratories.

National Cancer Institute Conducts Male Breast Cancer Study

The Medicine Branch of the National Cancer Institute is conducting a study involving male patients with breast cancer. Physicians treating such patients may refer them to the Institute. Patients will be accepted at all stages of diseases if they are ambulatory, under 65 years of age, and in otherwise good health. The studies will involve evaluations of chemotherapy and hormone therapy. More details are available from: Attending Physician, Medicine Branch, National Cancer Institute, Clinical Center, Room 12N-226, National Institutes of Health, Bethesda, Maryland 20014, telephone: 301/496-4916.

The Ohio State Medical Association New Members

BUTLER
Kulumani M. Narasimhan, Hamilton
Aswath N. Subram, Fairfield

CLERMONT
Herman K. Headlam, Batavia
H. Charles Miller, Peebles

CUYAHOGA (Cleveland)
Minoru Adachi
Edgardo P. Amador
William R. Bohl
Julian A. Gordon
Robert P. Jacobson
Dusan N. Naunovich
Mohamed I. Nisar
Erwin R. Rabin
David E. Radebaugh
Helmut Schreiber
Richard M. Steinhilber
Erich W. Streib
Yoshiro Takaoka
Jeff Wacksman

HAMILTON (Cincinnati)
Stanley E. Broadnax
Douglas K. Brown
G. Thomas Gabrys
Charles L. Johnson
Christopher Kircher
Jeffrey H. Rinsky

JEFFERSON (Steubenville)
Young Jie Lee
Carolina Torres

LORAIN (Lorain unless noted)
Peter A. Esch, Elyria
Karl G. Heine
Sa Koo Lee, North Ridgeville
Hung Chien Ling
Aurora Miclat, Elyria
Romeo Miclat, Elyria
Teresita Ocampo
Paul F. Varley
Masao Siang-Su Yu, Amherst

MAHONING (Youngstown)
Richard L. Bernstine
Pang-Hsiung Huang
Volker K. H. Sonntag

MEDINA
Saldmon Meles, South Euclid
Jaseem Pasha, Piqua

MONTGOMERY (Dayton)
William L. Black
Eduardo G. Jones
Evelyn M. Mobley
Bahman Parandian
Samuel P. Pike
Mohammed W. H. Siddiqi
Jack E. Steele

STARK (Canton unless noted)
Hi-Suck Ahn
Bernhard Berger
Stanley Bertman
Julian P. Betita, Jr., Stow
Douglas L. Blocker
Donald E. Carter, Jr., Alliance
Mouhamed K. Kamel, Massillon
Gunil Kim, Massillon
S. David Krimins, North Canton
Tito Loyola
George Marderwald, Alliance
Michael McGrady, Alliance
Ramesh Mehta
Meade Perlman, North Canton
Carlos Rozenbom
David Schumaker, North Canton
Prasanna Soni

SUMMIT (Akron)
James J. Fitzgibbon

TRUMBULL (Warren)
Ofelia Bustamante
Marwin R. Rouweyha
Haw-Chyr-Wu

★
Specialized Service
IN
PROFESSIONAL LIABILITY INSURANCE
is a high mark of distinction

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

OHIO OFFICES:
CINCINNATI: Room 700, 3333 Vine Street, (513) 751-0657, L. A. Floherty
CLEVELAND: Suite 106, 23360 Chagrin Boulevard, Beachwood 44122, (216) 464-9950
A. C. Spoth, Jr., R. A. Zimmerman
COLUMBUS: 1989 West 5th Ave., (614) 486-3939, J. E. Hansel
TOLEDO: 1011 Sandusky St., Suite H, P.O. Box 331, Perrysburg 43551, (419) 874-8080, R. E. Stallter

Television Violence and the Child

Ingrid May, OSMA Auxiliary President

Television, that pervasive, persuasive communication medium housed in 98 percent of American homes, is under fire. A heated debate is going on between the television industry and a variety of concerned groups. Numbered among these groups is the AMA Auxiliary and many state and local auxiliaries.

In my inaugural address, I challenged the county auxiliaries to follow the AMA's call to undertake a program entitled "Education for Positive Viewing." This program should be directed first at the adult members of our communities since they must become aware of positive viewing habits in order to teach children to be selective in the types of programs they watch.

Because it grips the viewer's interest through both the eyes and ears, television has a strong fascination for children and many adults. The degree of fascination is such that by the time many children graduate from high school, they will have spent more time in front of the TV set than in the classrom.

Richard Palmer, M.D., Past President of the AMA, said: "If the programming a child is exposed to consists largely of violent content, then his perception of the real world may be significantly distorted, and his psychological development may be adversely affected."

So far, studies indicate that children learn behavioral patterns from television; that they tend to imitate behavior viewed on TV; and that they are more likely to imitate adult rather than peer behavior. Psychiatrist William Glaser feels that television has become the "single most destructive force in our society." His concerns include: children are not as strong as they used to be due to lack of physical activities; the epidemic of hyperactivity among children due to motionless sitting in front of the TV; disadvantaged, minority children experience the worst effects; and children who have become weakened by extensive television viewing find school more difficult.

The ability of television violence to transcend age, sex, or social background was documented in the 1972 Report of the Surgeon General, which analyzed more than 50 studies involving 10,000 children between the ages of three and 19 years. Psychologist Robert Liebert found that "the more violence and agression youngsters see on TV, regardless of their age, sex or social background, the more aggressive they are likely to be in their own attitudes and behaviors."

With these facts in mind, members of the OSMA Auxiliary are taking positive steps to make parents and children aware of the possible negative influence of television programs. Realizing that positive changes will come when value questions are asked, we participated in a television-related research project carried out by two professors in the Department of Special Education at Bowling Green State University.

In addition, the Auxiliary to the Academy of Medicine of Toledo and Lucas County, along with other local interest groups, formed the "Toledo Coalition Against Violence on TV." This group produced a brochure that describes the problems, effects, and some solutions to the question of television violence. This brochure has been distributed to parent-teacher association members throughout the Toledo area.

Children have neither money nor the vote. We, as parents, must be their advocates. The Auxiliary is asking that the following ideas be kept in mind when supervising the television viewing of children: (1) plan viewing time; make careful choices; (2) suggest programs you think will be good for children to watch; (3) suggest alternative activities; (4) discuss the attitudes communicated by TV's "bigger-than-life" characters; (5) use television programs as starting points for conversations; (6) when a program ends, TURN THE SET OFF; and (7) write letters to stations, networks, and sponsors.

When discussing television programs with children, possible topics should include: (1) Does the program appeal to the audience for whom it is intended? (2) Does the program present racial groups positively, and does it show them in situations that enhance the child's self-image? (3) Does the program present gender and adult roles positively? (4) Does the program present social issues that are appropriate for the child viewer? Can the child act on these issues on a child's level? (5) Does the program encourage worthwhile ideals, values, and beliefs? (6) Does the program present conflict a child can understand, and does it demonstrate positive techniques for resolving the conflict? (7) Does the program stimulate constructive activities? (8) Does the program separate fact from fancy? (9) Does the program present humor at the child's level? Does the program have a pace that allows the child to absorb and contemplate the material presented?

If we commit ourselves to guidelines, we, the audience of alert and capable critics who insist on public responsibility, will settle the argument regarding television programming. The question for parents no longer is: "Do you know where your children are tonight?" but rather "Do you know what your children are watching tonight?"

EMERGENCY PHYSICIANS
FULL-TIME AND DEPARTMENT DIRECTORS
INTERESTED IN EXCELLENCE
AND
CAREER ORIENTATION

AMERICAN EMERGENCY MEDICAL SERVICES is a rapidly graw-ing national Emergency Medicine Graup which emphasizes professianal grawth in Emergency Medicine through extensive medical educatian benefits as well as excellent compensatian far physicians qualified ta jain aur group practice full-time.

Opportunities for Emergency Department Directorships and full-time group practice exist with **AMERICAN EMS** in a variety af com-munity settings ta fit yaur preferred lifestyle. Our contracted Emergency Medical Services are lacated in urban, suburban, and rural acute haspitals acrass the United States.

If yau are selected, you will enjoy lucrative compensatian based upon a percentage of your Emergency Department's gross revenues, with a substantial guaranteed minimum income. Our central affice staff of health care prafessionals, highly skilled in Emergency Department sys-tems, finance, and cammunity relatians, will enable you to direct your energies ta the practice of medicine, without the burden of office aver-head and administrative headaches.

Perhaps mast impartantly, an Emergency Medicine practice with **AMERICAN EMS** offers yau the freedom af regular haurs, sa that yau can pursue yaur life's ather interest without untimely interruptions.

We offer a braad benefit package encompassing all malpractice insurance casts, fees assaciated with yaur preparatian for Emergency Medicine Boards, assistance in establishing your own professianal medical corporatian, liberal vacatian and health benefits.

We invite physicians who have had Emergency Department clinical experience ta send their curriculum vita and their geographical prefer-ence to Geaffrey M. Hosta, M.D., Executive Directar, American Emer-gency Medical Services, 606 Wilshire Blvd., Suite 504, Santa Monica, Califarnia.

If yau are seriaus abaut a grawth future in praviding high quality Emergency Medical Services, cantact **AMERICAN EMS** now.

Call Toll Free 800/421-6655

Classified Ads

Rates: $3 per line. Display classified: $5 per line. Minimum 3 lines per insertion. Ads measure 8 lines to the inch. Box number reply: Flat $5 charge in addition to line cost for up to and including three insertions. (Covers cost of mailing replies which are kept confidential.) Forms close the 10th day of the month preceding month of publication. Address all ads Attention: Classified Ad Department, ***The Journal.***

To assure prompt delivery, when replying to an advertisement over a ***Journal*** box number, address letters as follows: Box (insert number), c/o ***The Ohio State Medical Journal***, 600 South High Street, Columbus, Ohio 43215.

INTERNAL MEDICINE: Excellent practice, now solo, needs to add an IM physician. Board-qualified mandatory. Excellent community and hospital. Contact Robert Flint, MARION GENERAL HOSPITAL, Marion, Ohio 43302 or phone: 614/382-8211 or 382-3442.

POSITION WANTED: Pediatrician. Passed written boards. Board eligible in endocrinology. Interested in general pediatric practice either solo or group. Eligible for Ohio state license. Available now. Contact: Gupta B. Kuna, M.D., 2028 Court Street, Pueblo, Colorado 81003.

ERPG, INC.— OHIO: Seeking two, young, full-time, career-oriented, emergency room physicians. Salary $60,000 per year. Health and malpractice insurances paid. Partnership in two years. Ohio license required. Send complete curriculum vitae to: Metin M. Ercan, M.D., Mercy Medical Center, Springfield, Ohio 45504.

FAMILY PHYSICIANS WANTED: One or two, resident graduates or board eligible or certified to join two-man group. Large office, semi-rural small town, local college, good schools, excellent 325-bed local community hospital 35 miles from Columbus, Ohio. Great place to practice, live and raise a family. Granville Medical Center, Inc., Granville, Ohio, 43023, phone: 614/587-0115.

PEDIATRICIAN: Solo or associate practice in city of 40,000. Office space, housing, and excellent 250-bed general hospital with privileges available. Contact: Robert Flint, 614/382-8211 (weekdays) or 614/382-3442, MARION GENERAL HOSPITAL, McKinley Park Drive, Marion, Ohio 43302.

OB/GYN: Established OB/GYN partnership has too much to handle, must expand, add third physician. New facility. Excellent hospital within walking distance. Contact Robert Flint, 614/382-8211 (weekdays) or 614/382-3442, MARION GENERAL HOSPITAL, McKinley Park Drive, Marion, Ohio 43302.

EMERGENCY PHYSICIANS: Full-time, career-oriented, northeast Ohio. Compensation commensurate with experience and training. Liberal fringe benefits, including malpractice insurance. Full department status. Ohio license required. Write J. J. Cahill, M.D., 36001 Euclid Avenue, Willoughby, Ohio 44094, phone: 216/946-4546.

PSYCHIATRIST: For community mental health center using case-manager model. Begin $41,600. Board eligible. 32 hours per week. Private practice allowable. Liberal fringes. Moving expenses. Open October 1, 1977. Resume/three reference letters to Personnel, Scioto Paint Valley Mental Health Center, 50 Pohlman Road, Chillicothe, Ohio 45601, telephone 614/775-1260.

EQUAL OPPORTUNITY EMPLOYER

FAMILY PRACTICE — RURAL PRACTICE: Northwest/central rural/agrarian community of 1200/1500 needs family practice physician. Practice could expand to cover 3000/3500 population area. No physician now practicing. Community will support. Major regional hospital within driving distance. Contact ROBERT FLINT, MARION GENERAL HOSPITAL, MARION, OHIO 43302, phone 614/382-8211 or 382-3442.

M.D., L.L.B.: Seeks part-time position in Northeast Ohio. Excellent administrative and organizational skills. Write Box 800 Ohio State Medical Journal.

INTERNIST WANTED: Need additional internal medicine physician. Board qualified. Established group practice in Lakewood, Ohio. Excellent salary. Fringe benefits with full membership in group within one year. Reply Box 815, c/o Ohio State Medical Journal.

(Classified Ads continued on page 72)

FULL-TIME FACULTY POSITIONS AVAILABLE: Department of Family Practice, Wright State University School of Medicine. Both experienced practitioners and recent resident graduates encouraged to apply. Board certification or board eligibility a prerequisite. Areas of activity include undergraduate teaching, residency teaching, curricular planning, continuing education for practicing physicians, and multiple research opportunities. Limited practice opportunity also available if desired. Precise duties of faculty members tailored to individual interest and abilities. Interested physicians are directed to reply with curriculum vitae to John C. Gillen, M.D., Acting Chairman, Department of Family Practice, Wright State University School of Medicine, 601 Miami Blvd., West, Dayton, Ohio 45408.

Equal Opportunity/Affirmative Action Employer.

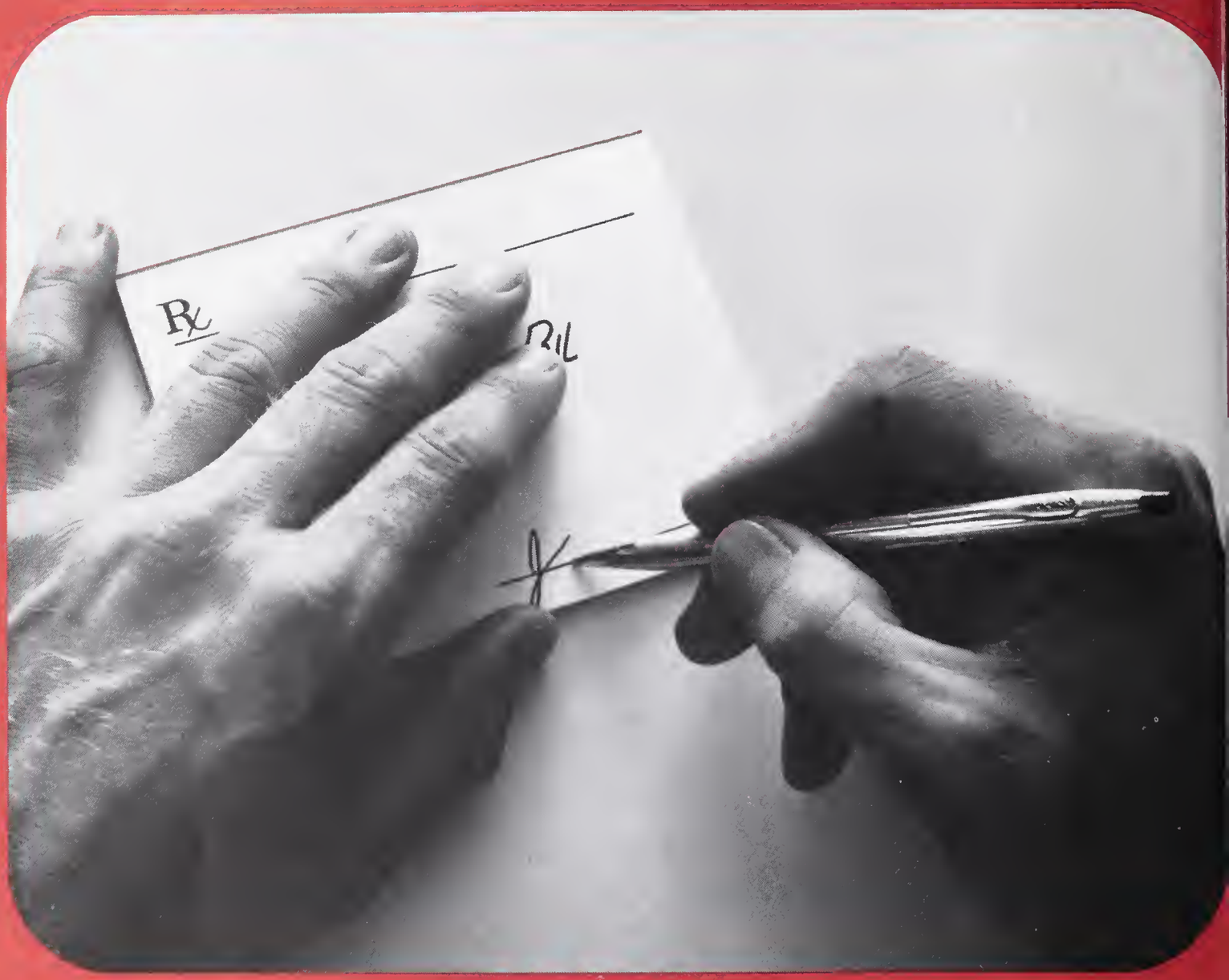
GENERAL MEDICAL OFFICES AVAILABLE FOR RENT: In Hartville, reportedly the fastest growing township in Ohio. New construction permitting individual furnishing. Physically attached to Cancer Center with diagnostic x-ray, laboratory, and pharmacy facilities. Contact George N. Swallon Agency, Canton, Ohio, 216/456-3495, or inquire of R. K. Loeffler, M.D., 650 South Prospect, Hartville, Ohio 44632.

AMBULATORY CARE CENTER — EMERGENCY DEPARTMENT STAFF PHYSICIAN, ATHENS, OHIO: 20,000 annual patient visits. Flexible scheduling, minimum guarantee/monthly bonus, excellent fringes. Contact Eric Jenison, M.D., O'Bleness Memorial Hospital, Athens, Ohio 45701, or call toll-free 800/325-3982 for details.

PROFESSIONAL OFFICE: Warren, Ohio. Approximately 1,000 sq. ft. Off-street parking. Will subdivide to suit tenant. Ideal for general practitioner or internist. Laboratory and surgeon in building. Contact: Physicians & Surgeons Laboratory, 210 Scott St., Warren, Ohio 44483, phone 216/395-3888 or 889-2538.

PSYCHIATRY STAFF OPENING: Board-eligible or board-certified psychiatrist in a reorganized service of outpatient-inpatient programs with 550 operating psychiatric beds and 40,000 outpatient visits. The environment is healthy; work standards high. An unusual opportunity for personal development and individual contributions to organizational upgrading. USCSC fringe benefits. Nondiscriminating in employment. Send application and resume to Chief of Staff, Paul F. Fletcher, M.D., VA Hospital, Chillicothe, Ohio 45601, phone 614/773-1141.

There is no substitute



yours...

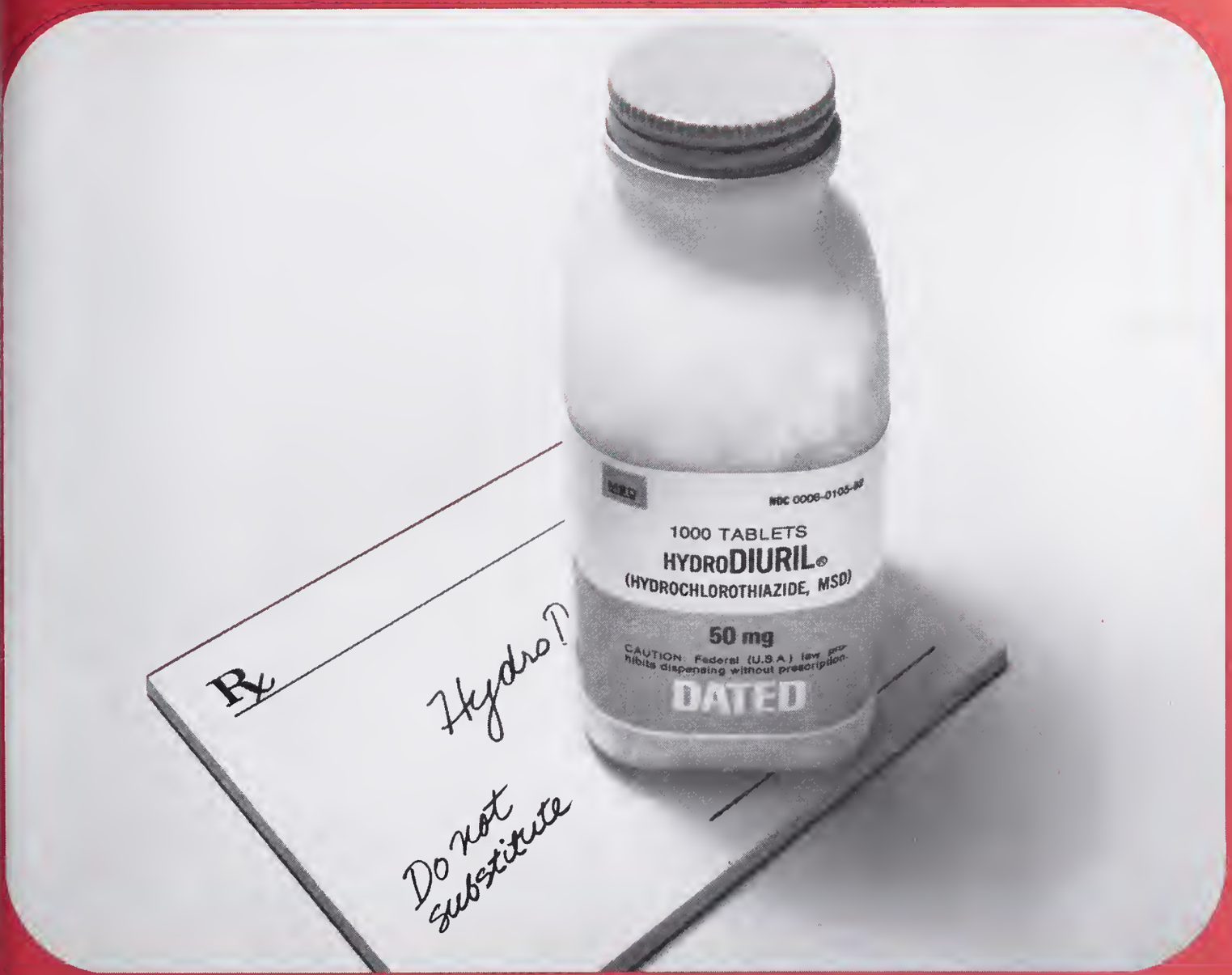
Contraindications: Anuria; hypersensitivity to this or other sulfonamide-derived drugs.

Warnings: Use with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects may develop in patients with impaired renal function. Use with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma. May add to or potentiate action of other antihypertensive drugs; potentiation occurs with ganglionic or peripheral adrenergic blocking drugs. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possibility of exacerbation or activation of systemic lupus erythematosus has been reported. Lithium generally should not be given with diuretics because they reduce its renal clearance and add a high risk of lithium toxicity. Read circulars for lithium preparations before use of such concomitant therapy. *Use in Pregnancy:* Thiazides cross placental barrier and appear in cord blood; in pregnancy, weigh anticipated benefit against possible hazards to fetus, including fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions that have occurred in adults. *Nursing Mothers:* Thiazides appear in breast milk; if use of drug is deemed essential, patient should stop nursing.

Precautions: Perform periodic determination of serum electrolytes to detect possible electrolyte imbalance. Observe all patients for clinical signs of fluid or electrolyte imbalance, namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting. Hypokalemia may develop, especially with brisk diuresis, in severe cirrhosis, with concomitant corticosteroid or ACTH therapy, or with inadequate oral electrolyte intake. Hypokalemia can sensitize or exaggerate response of heart to toxic effects of digitalis (e.g., increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content. Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients. Insulin requirements in diabetic patients may be increased, decreased, or unchanged; latent diabetes mellitus may become manifest. Thiazides may increase responsiveness to tubocurarine. Antihypertensive effects of the drug may be enhanced in postsympathectomy patients. May decrease arterial responsiveness to norepinephrine; this diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use. If progressive renal im-

for experience—



or ours.

pairment becomes evident, consider withholding or discontinuing diuretic therapy. Thiazides may decrease serum PBI levels without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged therapy; thiazides should be discontinued before testing for parathyroid function.

Adverse Reactions: *Gastrointestinal System*—Anorexia; gastric irritation; nausea; vomiting; cramping; diarrhea; constipation; jaundice (intrahepatic cholestatic jaundice); pancreatitis; sialadenitis.
Central Nervous System—Dizziness; vertigo; paresthesias; headache; xanthopsia.
Hematologic—Leukopenia; agranulocytosis; thrombocytopenia; aplastic anemia.
Cardiovascular—Orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).
Hypersensitivity—Purpura; photosensitivity; rash; urticaria; necrotizing angiitis (vasculitis) (cutaneous vasculitis); fever; respiratory distress including pneumonitis; anaphylactic reactions.
Other—Hyperglycemia; glycosuria; hyperuricemia; muscle spasm; weakness; restlessness; transient blurred vision.
Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

Note: When used with other antihypertensive drugs, careful observations for changes in blood pressure must be made, especially during initial therapy. Dosage of other antihypertensive agents must be reduced by at least 50 percent as soon as this drug is added to the regimen. As blood pressure falls under the potentiating effect of this agent, further reduction in dosage, or even discontinuation, of other antihypertensive drugs may be necessary.

How Supplied: Tablets containing 25 mg hydrochlorothiazide each in bottles of 100 and 1000 and single-unit packages of 100; Tablets containing 50 mg hydrochlorothiazide each in bottles of 100, 1000, and 5000 and single-unit packages of 100; Tablets containing 100 mg hydrochlorothiazide each in bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

J6HD04(528)

MSD
MERCK SHARP & DOHME

In hypertension

TABLETS: 25 mg, 50 mg, and 100 mg

HydroDIURIL®

(HYDROCHLOROTHIAZIDE|MSD)

GENERAL PHYSICIANS: Needed for full-time, salaried positions in student health care facility. Predictable daytime hours. Liberal vacations and long weekends at desirable times. Ohio licensure and enthusiasm for working with college-age patients essential: R. B. Rardin, M.D., Director, Student Health Service, Miami University, Oxford, Ohio 45056, phone 513/529-3333.

EMERGENCY PHYSICIAN: Northern and Southern Ohio, multiple openings with outstanding remuneration plus malpractice insurance. Write National Emergency Services, Inc., 25 Rolling Hills Road, Tiburon, California 94920 or call 415/435-0689 or 9751.

UNEXPECTED OPENING: In obstetrics and gynecology for a first-year resident (Grad II). Seven-hundred bed hospital with medical school affiliation known for its postgraduate medical education in all phases of medicine. Position available July 1, 1978. Reply Box 816, c/o Ohio State Medical Journal.

FOR RENT: South End, Cols. Estab. G.P. office; 4 rms.. central a/c, parking. Phone 614/224-6972 or 231-1987.

HOUSE PHYSICIANS WANTED: For a community hospital located in northeast Ohio. Housing and uniform allowances provided. Attractive fringe benefits, including insurance. Salary negotiable. Must have current Ohio licensure. Reply Box 813 c/o Ohio State Medical Journal.

MARION, OHIO: Excellent opportunities in Central Ohio. Existing and new, solo, partnerships, or association practices available and seeking physician support. Top compensation— reliable cross coverage. Exceptionally attractive, 250-bed, well-equipped regional medical center hospital within walking distance from offices. Industry and agriculture support city/45,000; county/65,000; and total trade area/250,000. Excellent schools and residential areas. Fifty-minute, easy drive to Columbus. Active need for—

OB/GYN
FAMILY PRACTICE
INTERNAL MEDICINE
OTOLARYNGOLOGY
PEDIATRICS
ORTHOPEDIC SURGERY
EMERGENCY MEDICINE
ANESTHESIOLOGY
GENERAL SURGERY

We are seeking either rural or city-oriented physicians. Send C.V. or contact— ROBERT FLINT, Marion General Hospital, MARION, OHIO 43302 — or call 614/382-8211 or 382-3442 any time.

TIRED OF ICE AND SNOW? COME SOUTH! Need all specialties. Situations available in all southern states. Immediate need for primary care physicians in NC, SC, Ga., Ala., Miss., and Tenn. Most are groups providing office, equipment, insurances, retirement program, profit sharing, and other perks Salaries $50-60K range. OUR FEE IS PAID! Send CV with details to Medical Search, 3274 Buckeye Road, Atlanta, Georgia 30341.

GENERAL SURGICAL RESIDENCY: Fully-approved, five-year residency at Cleveland's Lutheran Medical Center offers two positions at PGY2 level, beginning July 1978. Candidates must be graduates of American or Canadian schools of medicine. Contact: Joseph C. Avellone, M.D., Director of Surgery, Lutheran Medical Center, 2609 Franklin Boulevard, Cleveland, Ohio 44113.

CINCINNATI, OHIO: Emergency department director for 650+-bed hospital. Other full-time positions available. Starting salary $55,000 plus insurance package, malpractice, pension, and four-weeks paid time off. Contact Medical Health Services, Inc., 5002 Ridge Avenue, Cincinnati, Ohio 45209, phone: 513/631-0200.

FAMILY PRACTICE: Existing general practices need new partners or associates. Top medical community. Excellent general hospital. Offices and cross coverage available. Contact: ROBERT FLINT, Marion General Hospital, MARION, OHIO 43302, telephone: 614/382-8211 or 382-3442 any time.

MENTOR, OHIO: New office building. $10/sq. ft. includes all improvements to your design with option to buy building. Inquiries to: G. Guttmann, 26300 Euclid Avenue, Euclid, Ohio 44132.

COLUMBUS-BASED PHYSICIAN DESIRES: Part-time job in Columbus or nearby small town. Wishes to work one 24-hour shift a month, preferably a Saturday. Would consider covering a hospital or working a small emergency room, etc. Call 614/488-2457 after 6 PM.

OSMA Placement Service Ads

UROLOGIST: Available July 1978. Desires location in areas 3, 4 or 5 in community that is rural with metropolitan ties, suburban metropolitan or metropolitan with population over 100,000. Interested in solo or group practice with part-time or full-time academic appointment. Eligible for specialty board examination in July 1978. Contact Box P-23 c/o Ohio State Medical Journal.

INTERNIST: With gastroenterology subspecialty available July 1978. Passed specialty board examination June 1977. Desires location in areas 2, 3, 4 or 5 in suburban metropolitan or metropolitan community with population of 15,000 to 100,000. Interested in small group practice with part-time academic appointment, full-time academic appointment or governmental position. Contact Box P-21 c/o Ohio State Medical Journal.

INTERNIST: With cardiology subspecialty including invasive cardiology. Currently available. Desires location in areas 1, 2, 3 or 5 in suburban metropolitan or metropolitan community with population of 50,000 to 500,000. Prefers group practice. Contact Box P-18 c/o Ohio State Medical Journal.

EMERGENCY PHYSICIAN: Available July 1979. Desires group practice in community that is rural with metropolitan ties with population of 15,000-50,000. Eligible for specialty board examination July 1979. Contact Box P-22 c/o Ohio State Medical Journal.

GENERAL PRACTITIONER: Available August 1978. Desires central Ohio community that is suburban metropolitan with population of 15,000 to 50,000. Interested in solo or small group practice. Contact Box P-20 c/o Ohio State Medical Journal.



OPHTHALMOLOGIST: Available July 1978. Desires community that is rural with metropolitan ties, suburban metropolitan or metropolitan. Population 15,000 to 500,000. Interested in group practice. Eligible for specialty board examination in fall 1978. Contact Box P-19 c/o Ohio State Medical Journal.

FEBRUARY 1978
Volume 74, Number 2

THE OHIO STATE Medical Journal



LIBRARY
U.C. SAN FRANCISCO
MAR 3 1978

PUBLISHED BY THE OHIO STA

THE LIBRARY
ACQUISITIONS DIVISION
UNIVERSITY OF CALIFORNIA, SAN FRAN.
SAN [illegible]ISCO, CALIFORNIA 94143

Her next attack of cystitis may require

the Bactrim 3-system

1. In the urinary tract

Highly effective with fewer recurrences compared to ampicillin or cephalexin

Bactrim has shown high effectiveness not only against *Escherichia coli*, the major uropathogen, but also against most other *Enterobacteriaceae* involved in recurrent UTI. Substantially fewer recurrences have been recorded with Bactrim, as compared to ampicillin or cephalexin.*

Results one month after cessation of treatment

	No. of patients	Antimicrobial therapy	% Negative cultures†
Study 1	80	10-day Bactrim	71.3
	76	10-day ampicillin	56.6
Study 2	60	28-day cephalexin	56.7

Bactrim tablets were used. Bioequivalency studies show one Bactrim DS tablet to be equivalent to two regular strength Bactrim tablets.

*Data on file, Medical Department, Hoffmann-La Roche Inc.
†Criterion: 1000 or fewer organisms/ml urine.

2. In the vaginal tract

It appears from recent studies that the likelihood of recurrent UTI is enhanced by the establishment of large numbers of *E. coli* or other uropathogens on the vaginal introitus.

Bactrim combats uropathogens colonizing the vaginal introitus

Trimethoprim has the distinctive ability to diffuse into vaginal fluid in effective concentrations, thereby reducing or eliminating the number of pathogens in the vaginal introitus, from which they often migrate into the urethra. Bactrim acts to minimize this source of recurrent cystitis in the female.



ROCHE

counterattack

3. In the lower intestinal tract

By its selective action against *Enterobacteriaceae* in the bowel, Bactrim reduces the risk of introital colonization by fecal uropathogens.

Attacks colonic reservoir of uropathogens without significant effect on normal ecologic balance

Bactrim's wide spectrum makes it valuable against most gram-negative bacteria that cause UTI recurrences, yet Bactrim has *no* significant effect on other normal, necessary intestinal flora. Also, Bactrim has rarely been found to cause the intestinal discomfort or fungal overgrowth often associated with broad-spectrum antibiotics.



Bactrim™ DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d.

To clear her infection* and combat reinfecting organisms

*Due to susceptible strains of *E. coli, Klebsiella-Enterobacter* and *Proteus mirabilis, vulgaris* and *morganii.*

Please see summary of product information on following page.



"...Sleep that knits up the ravell'd sleave of care..."

– WILLIAM SHAKESPEARE, *MACBETH, ACT II, SC. 2*

Insomnia
a shade of blue that often accompanies depression

And, in anxiety/depression, Adapin® (doxepin HCl) often helps restore disturbed sleep patterns, such as early morning awakening, with a single daily dose at bedtime.[1] Adapin quickly relieves the patient's anxiety, gradually brightens his mood and outlook, with optimal antidepressant response usually evident within two to three weeks.

1. Goldberg HL, Finnerty RJ, Cole JO: Doxepin: Is a single daily dose enough? *Am J Psychiatry* 131:1027-1029, 1974

Brief Summary of Prescribing Information
ADAPIN® (doxepin HCl) Capsules

Indications—Relief of symptoms of anxiety and depression.

Contraindications—Glaucoma, tendency toward urinary retention, or hypersensitivity to doxepin.

Warnings—Adapin has not been evaluated for safety in pregnancy. No evidence of harm to the animal fetus has been shown in reproductive studies. There are no data concerning secretion in human milk, or on effect in nursing infants.

Usage in children under 12 years of age is not recommended. MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with this drug, as serious side-effects and death have been reported with the concomitant use of certain drugs and MAO inhibitors.

In patients who may use alcohol excessively potentiation may increase the danger inherent in any suicide attempt or overdosage.

Precautions—Drowsiness may occur and patients should be cautioned against driving a motor vehicle or operating hazardous machinery. Since suicide is an inherent risk in depressed patients they should be closely supervised while receiving treatment. Although Adapin has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind

Adverse Reactions—Dry mouth, blurred vision and constipation have been reported. Drowsiness has also been observed.

Adverse effects occurring infrequently include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as sweating, tachycardia and hypotension. Weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash and pruritus may also occur.

Dosage and Administration—In mild to moderate anxiety and/or depression: 10 mg to 25 mg t.i.d. Increase or decrease the dosage according to individual response. **Usual optimum daily dosage is 75 mg to 150 mg** per day, not to exceed 300 mg per day.

Antianxiety effect usually precedes the antidepressant effect by two or three weeks.

How Supplied—Each capsule contains doxepin, as the hydrochloride: 10 mg, 25 mg and 50 mg capsules in bottles of 100 and 1000.

For complete prescribing information please see package insert or PDR.



When they see life in shades of blue... help them see life in all its colors.

Adapin®
(doxepin HCl)

single daily dose recommended h.s.



10-mg capsules
25-mg capsules
50-mg capsules

PENNWALT

Pennwalt Prescription Products
Pharmaceutical Division
Pennwalt Corporation
Rochester, New York 14603

Mark Rothko's Paintings --- Suicide Notes?

James G. Ravin, M.D.
John J. Hartman, Ph.D.
Ralph I. Fried, M.D.

MARK ROTHKO (1903-1970) was one of the most influential 20th century artists. He was a founder of the school of Abstract Expressionism. Rothko's individual style was "color field" painting. His paintings are large canvases simply composed of rectangles that appear to float against a contrasting background. His paintings have become very popular during the past decade and prices for them have soared. In addition, the Rothko name has made headlines recently due to a lawsuit by his heirs against the executors of his estate. Rothko committed suicide in 1970 at the peak of his artistic career: he left no written note to explain the reasons for his suicide. We feel his paintings might be viewed as suicide notes.

Dr. Ravin, Toledo, Clinical Assistant Professor, Section of Ophthalmology, Medical College of Ohio at Toledo; Staff Member, Flower, Riverside, St. Vincent, and Toledo Hospitals.
Dr. Hartman, Ann Arbor, Michigan, Associate Professor, Department of Psychiatry, University of Michigan Medical School.
Dr. Fried, Cleveland, practicing pediatrician; Staff Member, Mt. Sinai, St. Luke's, and University Hospitals.
Reprint requests to 3103 Executive Parkway, Toledo, Ohio 43606 (Dr. Ravin).
Submitted January 5, 1978.

Rothko was born in Russia and emigrated to the United States in 1913. He attended Yale University from 1921 to 1923 but dropped out to "wander around, bum about, starve a bit."[1] He began his artistic career relatively late (in his 20s) and settled in New York City. His early style was Surrealistic. By the late 1940s, he developed a personal style of rectangular forms floating in space. In the 1950s, he was recognized, along with Pollock, de Kooning, and Kline, as a major force in contemporary art. He had successful exhibitions at the Art Institute of Chicago and the Museum of Modern Art in New York. In 1964, he was given the opportunity to create a series of paintings for an ecumenical chapel in Houston. Enthusiastically, he began to work on this project, which he saw as the culmination of his life work, similar to Matisse's painting in the chapel at Venice and Michelangelo's in the Sistine Chapel.

The chapel painting consumed most of Rothko's time from 1964 to 1966; unfortunately, he did not live to see it dedicated in 1971. During the last three years of his life, Rothko was a most unhappy man. On January 1, 1969, he moved out of his home, leaving his wife and children, and lived in his Bowery studio. His last years were marked by insecurity, extreme dependency needs, insomnia, and excessive smoking and drinking. Behind an arrogant facade was a sensitive, vulnerable, depressed

man. On February 25, 1970, he took an overdose of barbiturates, slashed his forearms, and died in his studio.

Why did Mark Rothko commit suicide? After years of poverty, he had finally achieved fame and fortune. He was depressed, probably for a number of reasons. He may have had the self-doubts common to many who achieve sudden success: Am I really worth all this? Why is my painting suddenly in fashion? Why wasn't my talent recognized earlier? Am I being exploited? Will my work go out of fashion quickly? Is the art-buying public foolish and capricious? Are my agents treating me fairly?

Rothko was insecure and repeatedly depended on others to assure him that his paintings were good. He was hurt by critics that ignored him. He felt that some artists stole his ideas without ever acknowledging their source. He was appalled by current events and the marketing of art. Some critics doubted that there was any merit to his paintings. One critic recalled Ruskin's comments about Whistler, saying that Rothko's works were "paint thrown in the face of the public."[2] Rothko liked to tell the story of the woman who came to one of his shows and, in the midst of the canvases, asked the artist where the paintings were. Such stories made good jokes but were poor therapeutic reassurance.

Several insights to Rothko's personality and his depression may be found in his paintings. One clue to his depression is the change with time in the colors he used. Although some may argue that this was the "natural" evolution of his style, there must have been reasons for the evolution, and depression was the most likely cause.

During the early 1950s, his colors were bright and cheerful yellows, oranges, reds, and blues. When black was used, it was merely to create a contrasting background. While most critics were describing religious or mystical sensations derived from Rothko's paintings, one perspicacious critic sensed "impending doom" in them.[3] In the late 1950s, Rothko's colors were predominantly black, brown, and maroon. One critic noted that "death was very much in these pictures."[4] (See Cover.)

The Houston chapel paintings of 1964 to 1966 depend heavily on dark-red pigment, the shade of clotted blood. During the last three years of his life, Rothko entered a "black period" in which black, gray, and brown predominated.

Rothko felt unappreciated. He said: "The unfriendliness of society to his activity is hard for the artist to take."[5] His mood often was somber, and he spoke of his efforts to "project a tragic vision."[1] To him, "only tragic and timeless subject matter is worthy of painting."[1] He was fond of lyrical artists such as Matisse, but he studiously avoided flowery styles of painting. He saw his works as violent and said "a clear preoccupation with death" was basic to his art.[4]

Although often depressed, he could be a charming, witty companion. Betty Parsons, a friend and art dealer, said: "His temperament was always Russian and melancholy, even when things were going his way. But he could make black white and white black when he spoke. His wit was not at the expense of people, but at the expense of life."[1]

Psychologic interpretation of Rothko's emotion-laden paintings can tell us much about him. He conveyed his emotions via paint. As he said, the canvases contain "all my feelings about life."[6]

It is helpful to use information learned from Rorschach testing to analyze Rothko's paintings. The Rorschach ink blot test probably has been examined more than any other psychological test for its ability to predict behavior. Rorschach studies of suicidal patients have shown two characteristics to correlate with suicidal behavior: color and shading responses,[7] and representations of transparency or translucency.[8,9] Rothko's paintings amply display the first characteristic. Colors are shaded and blend into each other. His fields of color do not suddenly confront each other, instead, the colors shade into each other. The second characteristic, representation of transparency or translucency, also can be found in Rothko's paintings. His forms look like translucent clouds.

Suicidal patients often describe the Rorschach ink blots in terms that indicate transparency or translucency. They may describe snowflakes or x-ray-like images in the ink blots through which something else may be seen. One patient felt "frail and transparent, as though made of tissue paper."[10] The transparency response is significant because it indicates disorganization of the personality.[8] This may include loss of ability to differentiate oneself from others, which can result in aggression aimed at oneself (suicide).

Thus, despite achieving financial success and a fine reputation as an artist, Mark Rothko became depressed and committed suicide. His paintings might be viewed as pictorial suicide notes. Unfortunately, this conclusion came too late to be of help to the artist.

References

1. Glueck G: Mark Rothko (obituary). *New York Times* I:39, Feb 26, 1970.
2. MB: Mark Rothko at Parsons. *Art Digest* 23:27, 1949.
3. Ashton D: Mark Rothko. *Arts and Arch* 21:8, 1957.
4. Rubin W: Mark Rothko 1903-70. *New York Times* II:21, Mar 8, 1970.
5. Rothko M: The Romantics Were Prompted. *Possibilities* I:84, 1947 quoted by Selz P, in *Mark Rothko,* New York, Museum Modern Art, 1961, p. 9
6. O'Doherty B: *American Masters.* New York, Random House, 1973, p 153.
7. Applebaum SA, Colson DB: A reexamination of the color-shading Rorschach test response and suicide attempts. *J Proj Tech* 32:160, 1968.
8. Roth D, Blatt SJ: Spatial representations of transparency and the suicide potential. *Int J Psychoanal* 55:287, 1974.
9. Blatt SJ, Ritzler BA: Suicide and the representation of transparency and cross-sections on the Rorschach. *J Consult Clin Psychol* 42:280, 1974.
10. Alvarez A: *The Savage God.* New York, Random House, 1972 p 232.

Even brilliant surgery can be complicated by infection...



ANCEF® is effective in post-surgical infections*

- *Broad coverage of the major areas of post-surgical infection due to susceptible organisms. See Indications on next page.

- High Levels Present in Tissues and Fluids†
Ancef® achieves high concentrations in bone, synovial fluid, skin and soft tissues (such as pleural fluid, peritoneal fluid and lymph nodes). Ancef® is also excreted in a microbiologically active form in urine.

- High and Prolonged Serum Levels
A single 1 gram IV injection produced a mean peak concentration of Ancef® of 190 mcg/ml in healthy adult volunteers. After 4 hours, levels of 16.5 mcg/ml were still present.

- IM or IV Dosage Flexibility
The same dosage schedule can be used for both IM and IV administration.

- Well Tolerated
Most frequently reported adverse reaction is pain on injection. Please see next page for a complete list of reported adverse reactions. **Use with caution in patients with penicillin or other allergies.**

Please see next page for a brief summary of prescribing information, including indications, contraindications, warnings, precautions, and adverse reactions.

†Data on file, SK&F Medical Department. Tissue penetration is regarded as essential to therapeutic efficacy, but specific antibiotic tissue levels have not been directly correlated with specific therapeutic effects.

Smith Kline &French Laboratories
Philadelphia, Pa.

ANCEF® IV IM

brand of sterile

CEFAZOLIN SODIUM

(LYOPHILIZED)

Injection: 250 mg, 500 mg, and 1 gram vials

SK&F
a SmithKline company

ANCEF® IV IM

brand of sterile

CEFAZOLIN SODIUM

(LYOPHILIZED)

Injection: 250 mg, 500 mg, and 1 gram vials

Most infections can be treated with 500 mg. or 1 gram of 'Ancef' every 8 hours.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

Indications: Ancef® (sterile cefazolin sodium, SK&F) is indicated in the treatment of the following serious infections due to susceptible organisms.

Respiratory tract infections due to *Streptococcus (Diplococcus) pneumoniae, Klebsiella* species, *Hemophilus influenzae, Staphylococcus aureus* (penicillin-sensitive and penicillin-resistant), and group A beta-hemolytic streptococci.

Injectable benzathine penicillin is considered to be the drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever.

'Ancef' is effective in the eradication of streptococci from the nasopharynx; however, data establishing the efficacy of 'Ancef' in the subsequent prevention of rheumatic fever are not available at present.

Genitourinary tract infections due to *Escherichia coli, Proteus mirabilis, Klebsiella* species, and some strains of enterobacter and enterococci.

Skin and soft-tissue infections due to *S. aureus* (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci and other strains of streptococci.

Bone and joint infections due to *S. aureus.*

Septicemia due to *Str. pneumoniae, S. aureus* (penicillin-sensitive and penicillin-resistant), *P. mirabilis, E. coli,* and *Klebsiella* species.

Endocarditis due to *S. aureus* (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci.

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to 'Ancef'.

Contraindications: 'Ancef' is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: BEFORE CEFAZOLIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS.

SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Antibiotics, including 'Ancef', should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Usage in Pregnancy—Safety of this product for use during pregnancy has not been established.

Usage in Infants—Safety for use in prematures and infants under one month of age has not been established.

Precautions: Prolonged use of 'Ancef' may result in the overgrowth of nonsusceptible organisms. Careful clinical observation of the patient is essential.

When 'Ancef' is administered to adults or children with low urinary output because of impaired renal function, lower daily dosage is required (see dosage instructions in the package literature).

A false-positive reaction for glucose in the urine may occur with Clinitest® tablets; use glucose enzyme-type reagents.

Adverse Reactions: The following reactions have been reported: Drug fever, skin rash, vulvar pruritus, eosinophilia, neutropenia, leukopenia, thrombocythemia, and positive direct and indirect Coombs tests have occurred. Transient rise in SGOT, SGPT, BUN, and alkaline phosphatase levels has been observed without clinical evidence of renal or hepatic impairment. Nausea, anorexia, vomiting, diarrhea, and oral candidiasis (oral thrush) have been reported. Pain at the site of injection after intramuscular administration has occurred, some with induration. Phlebitis at the site of injection has been noted. Other reactions have included genital and anal pruritus, genital moniliasis, and vaginitis.

Administration and Dosage: 'Ancef' may be administered intramuscularly or intravenously after reconstitution. See the package literature for reconstitution procedures.

See the package literature for dosage recommendations.

How Supplied: 'Ancef' (sterile cefazolin sodium, SK&F)—supplied in vials equivalent to 250 mg., 500 mg. or 1 gram of cefazolin; in "Piggyback" Vials for intravenous admixture equivalent to 500 mg. or 1 gram of cefazolin; and in Pharmacy Bulk Vials equivalent to 5 grams or 10 grams of cefazolin.

Smith Kline &French Laboratories
Philadelphia, Pa.

SK&F
a SmithKline company

Ohio State Medical Journal Manuscript Guidelines

1. **EXCLUSIVE PUBLICATION.** Articles are accepted for publication with the understanding that they are contributed solely to this *Journal*. Permission for subsequent publication elsewhere must be obtained in writing from the Editor and from the Author.

2. **CORRESPONDENCE.** Address all correspondence relating to publication of scientific papers to: The Consulting Medical Editor, The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

3. **MANUSCRIPTS.** (a). Manuscripts should be submitted *in the original* on standard 22X28-cm (8½X11-inch) white typing paper.

(b). A copy of the manuscript should be retained by the Author.

(c). The entire text including case reports and lists of REFERENCES should be TYPED DOUBLE OR TRIPLE SPACED with margins of at least one inch on all sides.

(d). Tables, charts, and figures (illustrations) should be submitted separately from the text. They should be identified by number and by concise, descriptive titles. In the text, reference to them should be by number, eg, (Fig. 1).

4. **ILLUSTRATIONS.** (a). Illustrations (photographs, drawings, graphs, and tables) will be submitted to the printer for an estimate of cost. *The Journal* will assume $10 of this expense and the author will be billed by *The Journal* for the remainder.

(b). Each illustration should bear the figure number and the author's name on the back. When pertinent, the top of the photograph should be indicated. Do not clip, write on the back with a hard pencil, or otherwise mutilate the prints.

(c). Legends for the figures should be written on separate paper.

(d). The author must affirm that he has *written releases* on all photographs in which patients can be identified.

5. **ABSTRACTS.** *A short* (100-word maximum) abstract should be included with the article. It should cover the main points so that the reader may readily obtain the gist of the article.

6. **SUMMARIES.** The summary should be a concise restatement of the information given in the body of the article.

7. **REFERENCES.** (a). Lists of references should be at a minimum to conserve space and expense and be limited to those essential to the subject and to which actual reference is made in the text. The Editor reserves the right to reduce the number when necessary.

(b). References should be listed in the *order of their appearance in the text.*

(c). Authenticity and accuracy are the responsibilities of the Author.

(d). Each journal reference should include in this order: Author's last name and initials, title of article, name of journal (abbreviated in accordance with standard usage), volume number, inclusive page numbers, and year.

"2. Doe J, Roe RX: How to go about it. Ohio State M J 13:24-30, 1920"

Each textbook reference should include, in this order: Author's surname and initials, title of the book (capitalize all main words), edition, place of publication, name of the publisher, year of publication, volume, if more than one has been published, and page.

"5. Osler W: Modern Medicine, ed 3, Philadelphia, Lea & Febiger, 1927, vol 5, p 66."

8. **IDENTIFICATION OF PATIENTS.** Names, initials, hospital numbers, or any other identifiable labels, should *not* be used. It is preferable to identify patients for the purpose of publication by the use of numbers in series for the study being reported.

9. **METRICATION.** All measurements must be in metric units. English units should be given in parentheses following the metric in all cases where the measurement was originally done in English units.

10. **EDITING OF MANUSCRIPT.** Following acceptance of a manuscript for publication, it will be copy edited in conformance with the editorial standards of the American Medical Association, which *The Journal* follows. The copy-edited manuscript will be returned to the Senior Author for approval. At that time, he is asked to make all corrections and to have the manuscript retyped. Any changes, other than typographical errors, made by the Author after the manuscript is set in type will be billed to him at $1 per line.

11. **REPRINTS.** An order blank for reprints with a table covering cost will be sent with the galley proof to the Senior Author. *The Journal* does not profit on reprint orders.

12. **EDITORIAL ASSISTANCE.** Miss Mary Lou Brady, *Journal* Editorial Assistant, stands ready to assist the Author in preparing his manuscript. For his own assistance, however, the Author is encouraged to consult standard texts on medical writing, such as the *Style Book and Editorial Manual,* prepared by the Scientific Publications Division, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Journal Advertisers

Breon Laboratories, Inc.....107, 103
Brown Pharmaceutical Company, Inc.....94, 95, 130
Burroughs Wellcome Co.....98, 99, 103, 134
Cameron Memorial Hospital.....136
Harding Hospital, Inc.....111
Immke Circle Leasing.....133
Lilly, Eli and Company.....91
Mead Johnson.....125, 126, 127, 128
Medical Protective Company.....116
Medical World News.....117
Menendian Carpets.....88
New Orleans Graduate Medical Assembly...88
Ohio Medical Indemnity.....131
OSMA Annual Meeting.....92, 132
OSMA MED PREP Program.....101
Pennwalt.....76, 77
Pharmaceutical Manufacturers Association.....104, 105
Physicians Insurance Company of Ohio.....120
Practice Productivity, Inc.....112
Roche Laboratories, Div. of Hoffmann-LaRoche, Inc. .....Cover 2, 73, 74, Cover 3, Cover 4
Smith, Kline and French.....80, 81, 82
Turner and Shepard, Inc.....119
Warren-Teed Laboratories.....84, 85, 88
Wendt-Bristol Company.....111
Windsor Hospital.....124

Clinical experience & continuing confidence

KAON® ELIXIR was introduced in **1954**, followed by KAON® TABLETS in **1963.** Decades of clinical experience indicate acceptability, effectiveness, and safety in the majority of patients; should abdominal pain occur, therapy should be discontinued. Both have been taken by patient after patient, day after day, year after year, to correct potassium deficiencies. Both have consistently demonstrated their value when diet alone is inadequate for potassium replacement.

Kaon® Elixir
(potassium gluconate)

Kaon® Tabs
(potassium gluconate)

BRIEF SUMMARY
Kaon Tablets/Kaon Elixir

KAON® (potassium gluconate) TABLETS

Description: Each sugar-coated tablet supplies 5 mEq. of elemental potassium (as potassium gluconate 1.17 Gm.). Kaon Tablets are sugar coated, not enteric coated, which favors dissolution in the stomach and absorption before reaching the small intestine where the lesions with enteric potassium chloride have occurred. The sugar coating merely adds to palatability and ease of swallowing, not to delay absorption as does the enteric coating.
Indications: Oral potassium therapy for the prevention and treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. It may be used in the treatment of cardiac arrhythmias due to digitalis intoxication.
Contraindications: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause.
Warning: There have been several reports, published and unpublished, concerning nonspecific small-bowel lesions consisting of stenosis, with or without ulceration, associated with the administration of enteric-coated potassium tablets alone or when they are used with nonenteric-coated thiazides or certain other oral diuretics. These small-bowel lesions have caused obstruction, hemorrhage and perforation. Surgery was frequently required and deaths have occurred. Available information tends to implicate enteric-coated potassium salts, although lesions of this type also occur spontaneously. Therefore, coated potassium-containing formulations should be administered only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Coated potassium tablets should be used only when adequate dietary supplementation is not practical.
Precautions: In response to a rise in the concentration of body potassium, renal excretion of the ion is increased. With normal kidney function, it is difficult, therefore, to produce potassium intoxication by oral administration. However, potassium supplements must be administered with caution, since the amount of the deficiency or daily dosage is not accurately known. Frequent checks of the clinical status of the patient, and periodic ECG and/or serum potassium levels should be made. High serum concentra-

Time is the test of all things

1954
1978



tions of potassium ion may cause death through cardiac depression, arrhythmias or arrest. This drug should be used with caution in the presence of cardiac disease.

In hypokalemic states, especially in patients on a salt-free diet, hypochloremic alkalosis is a possibility that may require chloride as well as potassium supplementation. In these circumstances, Kaon (potassium gluconate) should be supplemented with chloride. Ammonium chloride is an excellent source of chloride ion (18.7 mEq. per Gram), but it should not be used in patients with hepatic cirrhosis where ammonium salts are contraindicated. Other sources for chloride are sodium chloride and Diluted Hydrochloric Acid, U.S.P.

It should also be kept in mind that ammonium cycle cation exchange resin, sometimes used to treat hyperkalemia, should not be administered to patients with hepatic cirrhosis.

Adverse Reactions: Nausea, vomiting, diarrhea and abdominal discomfort have been reported. The symptoms and signs of potassium intoxication include paresthesias of the extremities, flaccid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, fall in blood pressure, cardiac arrhythmias and heart block. Hyperkalemia may exhibit the following electrocardiographic abnormalities: disappearance of the P wave, widening and slurring of QRS complex, changes of the S-T segment, tall peaked T waves, etc.

Overdosage: Potassium intoxication may result from overdosage of potassium or from therapeutic dosage in conditions stated under "Contraindications." Hyperkalemia, when detected, must be treated immediately because lethal levels can be reached in a few hours.

KAON® (potassium gluconate) ELIXIR

Description: Each 15 ml. (tablespoonful) supplies 20 mEq. of elemental potassium (as potassium gluconate, 4.68 Gm.) with saccharin and aromatics. Alcohol 5%.

Indications: See Kaon Tablets.

Precautions: See Kaon Tablets.

In hypochloremic alkalosis, potassium replacement with potassium chloride (e.g., Kaochlor® 10% Liquid) may be more advantageous than with other potassium salts.

Adverse Reactions: See Kaon Tablets.

Overdosage: See Kaon Tablets.

WARREN-TEED
LABORATORIES, INC.
DIVISION OF **ADRIA LABORATORIES INC.**
COLUMBUS, OHIO 43215

Proceedings of the OSMA House of Delegates December 18, 1977 Special Session

A special session of the House of Delegates of the Ohio State Medical Association, convened pursuant to Article V of the Constitution, was held at the Neil House, Columbus, Ohio, December 18, 1977. The meeting was called for the purpose of reevaluating the Ohio State Medical Association's position on National Health Insurance.

William M. Wells, M.D., Newark, Ohio, Association President, called the meeting to order and asked the delegates to rise and participate in a silent prayer in tribute to Henry A. Crawford, M.D., Cleveland, President of the Ohio State Medical Board, and a Past President of the Ohio State Medical Association, who died December 15, 1977.

Dr. Wells requested a report from the Credentials Committee Chairman, Homer A. Anderson, M.D., Columbus, who announced that 129 of a possible 181 delegates were present and properly registered.

Dr. Wells then stated the purpose of the special session and reviewed the Association's present position with respect to National Health Insurance as follows:

> The number of county medical societies petitioning for this special session having met the Association's Constitutional requirements, this special session has been called for the following purpose as stated in the petition:
>
> ". . . at which meeting the House of Delegates can reevaluate its stand on National Health Insurance and 'submit recommendations--etc.'—as suggested by the House of Delegates of the AMA at its San Francisco meeting, June 20, 1977."
>
> For the information of members of this House of Delegates, I will quote verbatim the action of the AMA House of Delegates at the San Francisco meeting which is referred to in the petition for this special session:
>
> "RESOLVED, That the American Medical Association affirms its total opposition to the nationalization of the medical profession; and be it further
>
> "RESOLVED, That, as a part of the Board of Trustees' ongoing consideration of National Health Insurance, the House of Delegates refers to the Board of Trustees for study and report at the 1977 interim meeting the question of whether or not sections of HR 1818 and S 218 can be interpreted as vehicles that would permit the nationalization of the private practice of medicine or mandate placing the major burden of health insurance upon any one class of our society; and be it further
>
> "RESOLVED, That each state medical society be requested to submit its recommendations with regard to National Health Insurance to the Board of Trustees within the next sixty days."



Nino M. Camardese, M.D., Norwalk.



LEFT TO RIGHT: Warner W. Tuckerman, M.D., Cleveland, and AMA President John H. Budd, M.D., Cleveland.

Chapter Thirteen of the Bylaws of this Association states, — RULES OF PROCEDURE. The deliberations of this Association shall be in accordance with parliamentary usage as prescribed in the current edition of *Sturgis' Standard Code of Parliamentary Procedure* by Alice Sturgis.

Next I will quote from the Sturgis manual a statement regarding special sessions. "The order of business of a special meeting consists only of the proposals for consideration and decision and the subjects for discussion as stated in the call of the meeting."

In accordance with Resolution 1-76, a parliamentarian is present. He is Dr. Goodwin Berquist of The Ohio State University.

The meeting will recess for luncheon at 12 noon, and reconvene, *if necessary,* at 1:15 PM.

In your delegate's packet is a copy of the order of business for this special session.

Delegates are asked to confine their remarks to the subject of this session.

Microphones have been provided for the delegates. I ask each person recognized to state his name and the county medical society he represents.

Any delegate who speaks is asked not to seek the floor again until all others waiting to testify have done so.

For an orderly session, please do not attempt to speak until I recognize you by referring to the appropriate microphone number.

The policies of this Association in regard to National Health Insurance are based on two actions of the House of Delegates:

One is Resolution No. 25-71, adopted in 1971.



LEFT TO RIGHT: H. William Porterfield, M.D., Columbus, and Theodore J. Castele, M.D., Cleveland.

Two is the six points on which the House based its action last May in rejecting three resolutions. Each of those rejected resolutions would have reversed OSMA's position and also would have directed that OSMA strive to reverse the AMA's position.

Copies of the 1971 and 1977 actions of this House are found in your delegate's packet on a single sheet headed "Official Proceedings of the House of Delegates—Ohio State Medical Association."

In the 1977 Reference Committee hearing, H.R. 1818 was thoroughly reviewed.

There is in your delegate's packet a comprehensive summary of that bill. The summary was prepared by the AMA Legislative Department.

Your Ohio Delegation has always followed the House's policy on National Health Insurance in representing you at the AMA's 1977 Annual Convention.

At that convention, the AMA House of Delegates did, as noted in the petition for this special session, ask each state medical association to submit its National Health Insurance recommendations to the AMA Board of Trustees. OSMA honored that request by submitting to the Board of Trustees a statement outlining the 1971 and 1977 actions of this House.

MOST RECENTLY—Just eleven days ago—the American Medical Association House of Delegates voted—178 to 46—to continue strong and active support of H.R. 1818.

This action was based, in part, on the input from the state associations to the AMA Board of Trustees as requested by the AMA House last June.

I have reviewed for your information the actions of both this House and the AMA House of Delegates.

I will now entertain any motion pertaining to and limited to the specific purpose of this special session, namely, National Health Insurance.

Nino Camardese, M.D., Norwalk, a delegate from Huron County, was then recognized to present a resolution in the form of a motion. A number of delegates spoke to the motion.

H. William Porterfield, M.D., Columbus, a delegate from Franklin County, then moved to amend the resolution by substitution. An amendment proposed by Theodore Castele, M.D., Cleveland, a delegate from Cuyahoga County, was accepted by Dr. Porterfield and the seconder of his amendment.

An amendment to the amendment by Peter Overstreet, M.D., Toledo, a delegate from Lucas County, was adopted by the House by a vote of 72-51.

Dr. Castele then submitted a further amendment to the amendment, and it was adopted by the House.

The House then voted 113-13 to replace the original resolution offered by Dr. Camardese with the thrice-amended substitute resolution offered by Dr. Porterfield, as the main motion.

Subsequently the House adopted by a vote of 120-3 the following main motion:

Substitute Resolution

BE IT RESOLVED, That the OSMA oppose any plan for medical care that is government-controlled, and

BE IT FURTHER RESOLVED, That the OSMA support AMA efforts to effect an improvement in available private health insurance for those able to pay and an improvement of subsidy for the medically indigent people of this country, and

BE IT FURTHER RESOLVED, That the OSMA House of Delegates favor health insurance of the following type: (1) Voluntary on the part of the patient, (2) Purchased through the private sector, (3) An indemnity and/or co-insurance type, (4) A schedule of benefits for the patients (not a fee schedule for the doctor), (5) Free choice of physician, and (6) Government involvement be limited to its present involvement, and

BE IT FURTHER RESOLVED, That H.R. 1818 as presently constituted does not satisfy all of the above principles and has other important deficiencies, and therefore, OSMA can no longer support H.R. 1818 as presently written and urges the AMA to take appropriate steps to correct the above deficiencies.

The House was then declared adjourned by Dr. Wells.

ATTEST: Hart F. Page, CAE
Executive Director



OSMA President William M. Wells, M.D., Newark.

Modane®
(danthron)
LAXATIVE TABLETS

one tablet usually brings
gentle, overnight relief

WARREN-TEED
LABORATORIES, INC.
DIVISION OF ADRIA LABORATORIES INC.
COLUMBUS, OHIO 43215

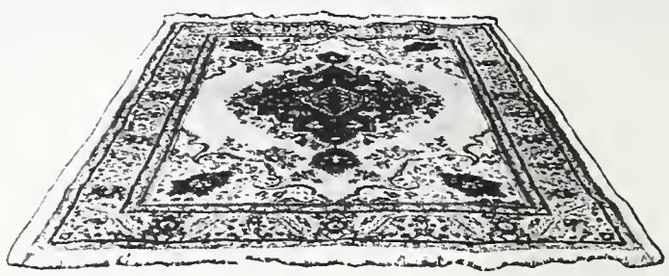
In Columbus
for over 65 years, since 1909,
K. A. Menendian
has been known for
the finest quality and best values in
ORIENTAL RUGS.

We carry a complete selection of rugs from mats to mansion sizes. Over 1500 rugs in stock from Iran, India, China, Pakistan, Turkey, etc.

See over 4,000 samples in our newly remodeled carpet showroom from Karastan and other fine mills.

We specialize in Oriental rug cleaning and repairing.

K.A.Menendian
1090 West Fifth Avenue
294-3345



Announcing the

41st ANNUAL NEW ORLEANS
MEDICAL ASSEMBLY

March 31 - April 4, 1978

The Fairmont — New Orleans

THE HIGH RISK PATIENT

Accreditation: AMA Category I, Physicians' Recognition Award, American Academy of Family Practice, American College of Emergency Medicine, Category I.

Adolph A. Flores, Jr., M.D., President; Oliver H. Dabezies, Jr., M.D., F.A.C.S., Director of Program.

Registration Fee: $200 non-member physicians; $100 military; $100 registered nurses; Complimentary: students, residents, interns and Fellows.

Write or Phone: New Orleans Graduate Medical Assembly, Room 1538, Tulane Medical Center, 1430 Tulane Ave., New Orleans, LA 70112. Call (504) 525-9930.

• Presidential Reception • Exhibitors' Champagne Reception • Mississippi River Cruise aboard SS Natchez • Superdome Tour, luncheon & fashion show for wives & guests.

Spring Fiesta, March 31, 1978. "A Night in Old New Orleans", Jackson Square.

Legislative Update

the federal scene

(Courtesy the OSMA Department of Federal Legislation and the AMA Washington Office)

AMA Begins Work on Voluntary Cost-Containment Program

The American Medical Association, the American Hospital Association, (AHA) and the Federation of American Hospitals (FAH) have accepted an unusual challenge from Congress to develop a voluntary hospital-and-health-care cost-containment program.

The challenge was posed by Rep. Dan Rostenkowski (D-Ill.), Chairman of the House Ways and Means Subcommittee on Health. In a House speech, the lawmaker conceded that Congress would not be able to resume deliberations on the Administration's controversial cost-containment proposal until this February. During this brief grace period, he said, the three major provider organizations should take the initiative "and effectively and significantly restrain cost increases on a voluntary basis."

Government intervention and the imposition of controls "should be a last resort," asserted Rostenkowski, raising the possibility that the Administration's plan for a 9% "CAP" on hospital revenue increases might be in deep trouble if the private sector satisfies the lawmakers in the interim.

James H. Sammons, M.D., Executive Vice-President of the AMA; President John A. McMahon of the AHA; and Director Michael Bromberg of the FAH made the following joint statement:

Our three organizations, at the instruction of our respective officers, are beginning now to organize a national steering committee of hospital people, doctors, insurers, consumers and others with a major stake in hospital cost containment. We will ask this committee, which we expect to have its first meeting within the next several weeks (December 1977), to develop the goals and mechanisms, first, of a voluntary program to reduce the rate of increase in hospital costs, and, second, of a voluntary program to reduce the rate of increase in health care costs as a whole. We will also encourage the development of similar steering committees at the state level to help implement these programs.

"The primary enforcing power in the program will be public accountability," said Director Bromberg. The AMA and the AHA have launched a voluntary program in hopes of averting a federal "CAP" on hospital revenues. Bromberg told the Washington Business Group on Health that hospitals "that fail to meet the screening criteria will be listed periodically. The review and findings of industry committees at the state level, as to the justification for each hospital's exceeding the screen, will be made public."

Bromberg said the anticipated publicity attendant on any hospital which fails to stay within the screen and the public exposure of the reasons why is expected to provide a substantial incentive to a hospital to restrain its charge increases. The FAH leader emphasized his belief in the private sector's ability to devise a workable alternative to an "arbitrary CAP" and to engage in voluntary enforcement of such a plan, saying:

If we fail, then government will take even more control of the health system. If we don't bite the bullet, government will assume management responsibilities from health providers, insurers and industry. The result will be more inflation and less quality.

Government Urges Public To Seek Opinions on Surgery

The federal government plans a major campaign to urge the American public to seek opinions on surgery. The unusual and precedent-setting program involving patients' dealings with physicians will be conducted by the Department of Health, Education, and Welfare (HEW). Both Medicare and Medicaid programs will be geared to encourage second opinions.

The policy was announced by Hale Champion, HEW Under Secretary, before the House Commerce Subcommittee on Oversight and Investigations. The Subcommittee, headed by Rep. John Moss (D-Calif.), has been holding hearings this year and issuing reports charging there is much unnecessary surgery in the United States. Champion told Moss:

. . . you have been right.

Comparisons with prepaid delivery, geographic variations in rates of surgery, and historical trends all point to the fact that there is more surgery in the United States today than there ought to be.

Accordingly, we are going to begin a major effort to encourage the American public, and especially our own beneficiaries, immediately to seek second opinions.

The Department has been instructed to remove the remaining legal barriers to patient-elected second opinions in Medicare. States will be requested to implement as quickly as possible active second-opinion programs for Medicaid.

According to HEW, if two physicians disagree, Medicare will pay for a third opinion if the patient desires one. At present, Medicare will pay for a second surgical opinion if the physician agrees to the advisory or orders it. But the physician's acceptance is, at present, mandatory. In the future, the patient would be reimbursed for a second opinion if the initial physician believes it unnecessary. One question to be answered is whether the patient must receive a negative response on a second opinion from the first physician, or simply could go off on his own to get a second opinion without even asking the physician.

Champion also told the Moss Subcommittee that he will ask professional standards review organizations (PSROs) "to move aggressively into review of surgical services." Champion said that with the advice of the National PSRO Council, "We're going to develop criteria for ten of the most common surgical procedures and distribute them to the PSROs by this February" (February 1978). By January 1979, criteria for 75% of the most common surgical procedures within each specialty will be prepared. He said: "We will do our best to see that these criteria are specific and measurable, and applied without unreasonable modification by the local PSROs."

Legislative Update

the state scene

(Courtesy the OSMA Department of State Legislation)

Ohio Senate Passes SB 163

In late January, the Ohio Senate voted to permit optometrists to administer "diagnostic pharmaceutical agents." Senate Bill 163 (Jackson, D-Cleveland) was approved by a vote of 20 to 11.

Sen. Morris Jackson, the Assistant Majority Leader and sponsor of the measure, told the members of the Senate that the enactment of SB 163 was "crucial to the delivery of quality eye care for the citizens of Ohio because optometrists are the only eye professionals in rural areas."

The OSMA and the Ohio Ophthalmological Society have strongly opposed the Ohio Optometric Association's bill that will allow non-medical practitioners to administer dangerous drugs.

The opposition arguments during the 1½-hour floor debate were presented primarily by Sen. Marigene Valiquette (D-Toledo). She warned the senators that the optometrists' professional experience and education do not enable them to diagnose systemic problems in the eye, nor can they treat the damaging reactions sometimes caused by the use of drugs on the eye. Statutory permission to use drugs does not substitute for the medical practitioner's years of clinical training.

Sen. Anthony Calabrese (D-Cleveland) and Sen. John Mahoney (D-Springfield) also warned the members of the Senate of the lack of educational requirements in the bill and the need for medical supervision when these dangerous drugs are used on patients. The bill was subsequently amended to require 50 hours of education, including 20 hours of clinically-supervised training prior to the granting of a license to use so-called "diagnostic drugs."

The following senators voted against passage of SB 163. Thank-you notes can be sent to their offices at the Statehouse, Columbus 43215. The senators voting *no* are Anthony O. Calabrese (D), Theodore M. Gray (R), Tony P. Hall (D), John K. Mahoney (D), Michael J. Maloney (R), Harry Meshel (D), Kinsey Milleson (D), Ronald L. Nabakowski (D), Robert E. O'Shaughnessy (D), Jerome Stano (D), and Marigene Valiquette (D).

The OSMA continues to oppose the legislation as it goes to the House of Representatives. Physician contacts should now be concentrated on Ohio House members.

Full-Time Legislature for Ohio?

The perennial issue of the length of legislative sessions has reappeared in Columbus. Legislators want to know how their constituents feel about a full-time Legislature. Several bills have been introduced to raise legislative salaries. Other bills have been introduced to limit legislative salaries and reduce legislative sessions. In the past six years, the length of legislative sessions has increased. Some other states limit their legislatures to 30-60 legislative days each year. As legislative sessions increase, there is increasing pressure to expand staff and constituent services. The increased salaries, staff, and constituent services will mean a full-time Ohio Legislature. Legislative leaders and members have different opinions on the necessity of a full-time Legislative. Your input would be welcomed as they review this question. Address your comments to your representative and senator.

Certificate-of-Need Bill Moves to Senate Floor

Senate Bill 349 (Valiquette, D-Toledo), Ohio's new statutory certificate-of-need legislation, will probably be approved by the Ohio Senate in early February. As presently drafted, the legislation will require a certificate of need from the local health service agency for a physician purchase of medical equipment costing over $100,000. The legislative intent to exclude from the certificate-of-need process all aspects of physician office placement or operation, except for the purchase of major items of medical equipment, is clear.

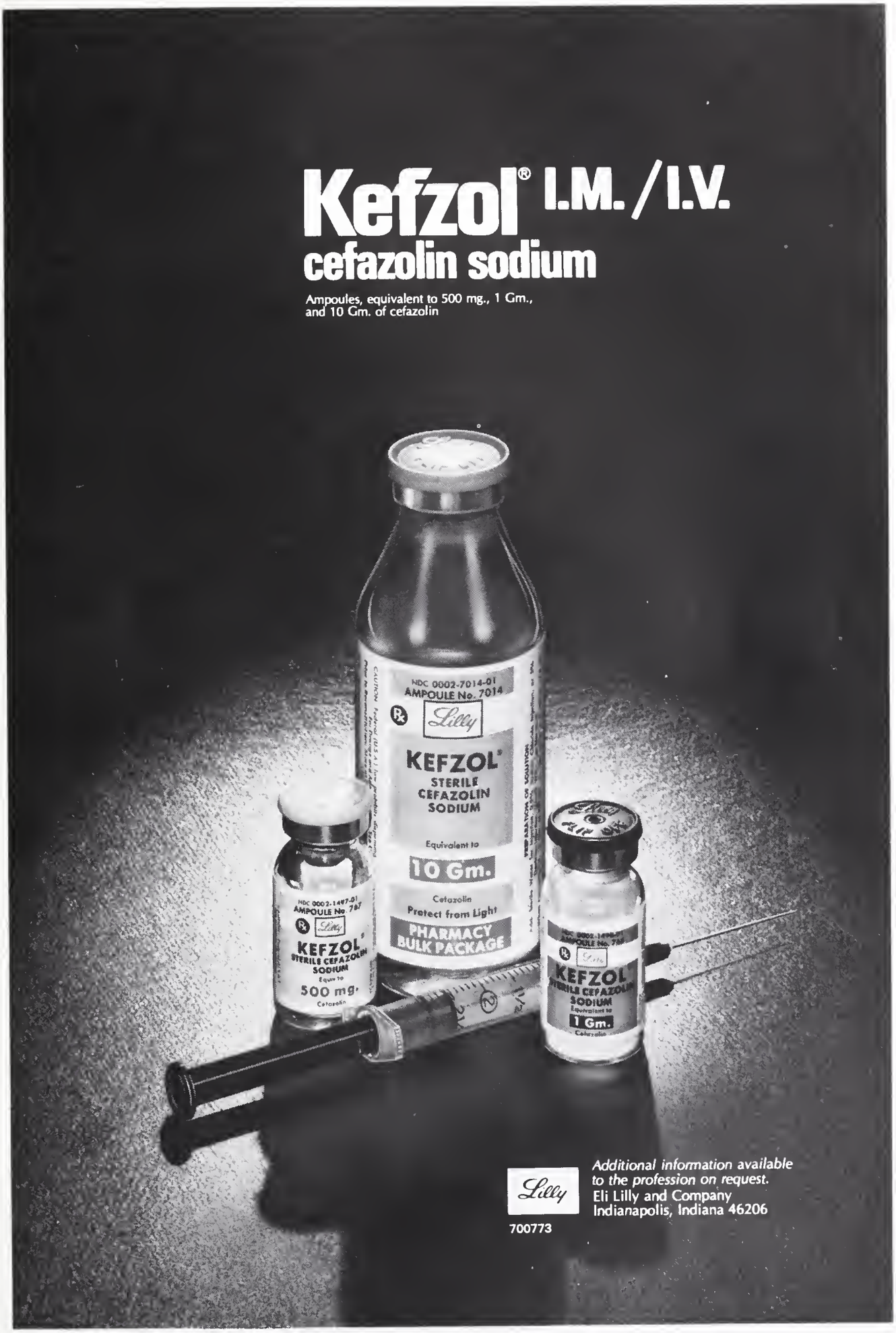
The OSMA continues to oppose this inclusion of a private physician's major medical equipment purchase in the new certificate-of-need process. An extensive memorandum explaining the OSMA position was sent to the county legislative chairmen and county society executive directors.

House Bill 687 Stalled in House Committee

An extraordinary fifth hearing has been scheduled for House Bill 687 (Batchelder, R-Medina), the bill to revise the time when the gonorrhea test of pregnant women, which is required by statute, must be given. Introduced at the request of several local physicians, the bill would revise the current requirement that a gonorrhea test be given at the first visit to a physician during pregnancy. Because of the difficulty involved in transporting the fragile gonococci, it is believed that a more accurate test could be given "just prior to delivery" when the hospital laboratory would be available to assess the culture. However, the Legislative Service Commission (the technical drafting service to the Ohio Legislature) felt that the time "just prior to delivery" could create several problems for physicians who are required by law to administer the test. The Ohio Hospital Association and the Ohio Department of Health both oppose any proposed change to the current requirement. All parties involved have been asked to meet and to attempt to resolve their differences.

Kefzol® I.M./I.V.
cefazolin sodium

Ampoules, equivalent to 500 mg., 1 Gm.,
and 10 Gm. of cefazolin



Additional information available
to the profession on request.
Eli Lilly and Company
Indianapolis, Indiana 46206

700773

Make Your Hotel Reservations

for the

1978 OSMA Annual Meeting

DAYTON, OHIO MAY 6-10

STOUFFER'S DAYTON PLAZA HOTEL.....5th and Jefferson Streets
(OSMA Headquarters)

Single $27
Double $32

SHERATON DAYTON DOWNTOWN.....21 S. Jefferson Street
(OSMA Co-Headquarters)

Single $24
Double $30

RAMADA INN / Downtown.....330 W. First Street
(Auxiliary Headquarters)

Single $20
Double $25

HOLIDAY INN / Downtown.....404 W. First Street

Single $23
Double $31

All rates subject to change. If you plan to share a room, please indicate name of roommate.

HOTEL RESERVATION BLANK

(Mail to Hotel of Choice)

_____
(Name of Hotel)

_____ Dayton, Ohio
(Address)

Please reserve the following accommodations during the period of the Ohio State Medical Association Annual Meeting, May 6-10, 1978 (or for period indicated). (Note: In order to accommodate you, please make reservations by April 15, 1978.)

_____ Single Room _____ Other Accommodations

_____ Double Room

Price Range_____ Guaranteed_____

No. of Persons_____ Arrival Date_____ Hour of Arrival_____ Departure Date_____

Name_____

Address_____

City_____ State_____ Zip_____

PLEASE VERIFY MY RESERVATION

If Rate or Accommodation requested not available, next highest rate or accommodation will prevail.
Rooms will be held until 6 PM unless payment is guaranteed.

A regular meeting of the Council of the Ohio State Medical Association was held Saturday, December 17, 1977 at the OSMA Headquarters' Office, 600 South High Street, Columbus, Ohio.

ATTENDANCE

OSMA Council Present: William M. Wells, M.D., Newark, President; John J. Gaughan, M.D., Cleveland, President-Elect; Robert G. Thomas, M.D., Elyria, Secretary-Treasurer; Stewart B. Dunsker, M.D., Cincinnati, First District Councilor; W. J. Lewis, M.D., Dayton, Second District Councilor; Alford C. Diller, M.D., Convoy, Third District Councilor; C. Douglass Ford, M.D., Toledo, Fourth District Councilor; Theodore J. Castele, M.D., Cleveland, Fifth District Councilor; C. Edward Pichette, M.D., Youngstown, Sixth District Councilor; Robert E. Rinderknecht, M.D., Dover, Seventh District Councilor; Richard E. Hartle, M.D., Lancaster, Eighth District Councilor; Thomas W. Morgan, M.D., Gallipolis, Ninth District Councilor; J. Hutchison Williams, M.D., Columbus, Tenth District Councilor; and S. Baird Pfahl, Jr., M.D., Sandusky, Eleventh District Councilor.

Absent: George N. Bates, M.D., Toledo, Past President; and William Dorner, Jr., M.D., Akron, Twelfth District Councilor.

Guests Present: John H. Budd, M.D., Cleveland, AMA President; P. John Robechek, M.D., Cleveland, Chairman, Ohio Delegation to the AMA; John H. Ackerman, M.D., Columbus, Director, Ohio Department of Health; James E. Pohlman, Esq., Columbus, OSMA Legal Counsel; and David L. Rader, Vice President/Administration, Physicians Insurance Company of Ohio.

OSMA Staff Present: Hart F. Page, Charles W. Edgar, Herbert E. Gillen, Jerry J. Campbell, Robert D. Clinger, Katherine E. Wisse, D. Brent Mulgrew, Robert E. Holcomb, Gail E. Dodson, Rebecca J. Doll, Linda Porterfield, Rick Ayish, David C. Torrens, and Judy Franklin.

The meeting was opened with a moment of silence in honor of Past President Henry A. Crawford, M.D., Cleveland, who died December 15, 1977.

ADMINISTRATION DEPARTMENT

The minutes of the November 19, 1977 meeting of the Council **were approved.**

FINANCIAL AND MEMBERSHIP DEPARTMENT

Membership statistics presented by Mrs. Wisse indicated a gain of 330 members over November 30, 1976.

Committee on Auditing and Appropriations

Minutes of the Auditing and Appropriations Committee meeting of December 16, 1977 were presented by Dr. Rinderknecht and were amended and **approved.**

Dr. Rinderknecht presented, and the Council **approved,** the budget for 1978. (See page 96.)

DEPARTMENT OF CONTINUING MEDICAL EDUCATION

Committee on Maternal and Neonatal Health

The Maternal Mortality Report for 1974, as prepared by the OSMA Committee on Maternal and Neonatal Health, was accepted as presented.

Committee on Education

Minutes of the November 17, 1977 meeting of the Committee on Education were presented by Mrs. Dodson and **were approved.**

Committee on Emergency and Disaster Medical Care

The Council **approved** a request from the Health Occupations Education Section of the Ohio Department of Education for the use of the Association's name on the program of four regional refresher training courses for Emergency Medical Technicians-A.

GOVERNMENT MEDICAL CARE DEPARTMENT

Joint Officers OSMA, OHA and OOAPS Committee

Mr. Gillen reported on a meeting of the officers of the OSMA, Ohio Hospital Association and Ohio Osteopathic Association of Physicians and Surgeons, November 30, 1977.

It was stated that the main topics for discussion included the implementation of a cost effectiveness program by the three Associations and the problem of obtaining CME credits for osteopathic physicians and surgeons who obtain continuing medical education from OSMA-AMA approved programs. The Council suggested that the OSMA Cost Effectiveness Committee meet with similar groups from the Ohio Hospital Association and the Ohio Osteopathic Association, along with Mr. Charles Parcell, of Ohio Medical Indemnity, Inc., with regard to further implementation of the plan.

Committee on Cost Effectiveness

Dr. S. Baird Pfahl, Chairman of the OSMA Committee on Cost Effectiveness, submitted, for study of the

(continued on page 94)

Council, the following statement with regard to cost effectiveness:

The cost of medical care is becoming a more and more significant factor in our economy due to general inflation as well as improvements in medical technology. Physicians need to be made aware of these costs and their control over some of these costs.

The concerns of the physicians regarding the costs of medical care should primarily address themselves to maintaining the quality of care this country deserves as well as how to deliver this quality care at the most "cost effective" level. While being aware of the cost factors, however, we must not decrease the quality of the care rendered. Some specific examples of how physicians might be made more aware of the cost of medical care might be the discussion at hospital staff meetings of the costs of particular specific diseases as well as the medical treatment of same. This can also be done with certain procedures, i.e. gastroscopy, cystoscopy, etc.

The technological advances made by medical science need to be evaluated on a scientific and cost effective manner. Physicians must be primarily responsible for these evaluation procedures in an objective fashion. The Council of the OSMA further suggests that "first dollar" insurance coverage is expensive because it tends to increase demand and utilization and that alternative methods of financing health care be evaluated by the insurance industry. We further feel that the education of the public regarding the medical, preventive, and sociologic aspects of health care be pursued vigorously by the Ohio State Medical Association.

Medical Staff Bylaws Policy Adopted

The Council of the Ohio State Medical Association voted to support the principle that Medical Staff Bylaws should not be adopted nor amended unilaterally by a hospital governing board without medical staff approval.

DEPARTMENT OF ORGANIZATION SERVICES

American Medical Association

Dr. Robechek and Dr. Budd reported on several major activities of the December meeting of the AMA House of Delegates.

The Council **approved** the support of B. Leslie Huffman, M.D., Maumee, for a position on the AMA Council of Continuing Physician Education.

PICO

David L. Rader, Vice President/Administration of Physicians Insurance Company of Ohio, presented the following data on the operation of the company:

(1) Effective January 1, 1978, PICO will be selling $1-million excess policies over certain other insurers' 200,000/600,000 primary policies.

(2) The PICO Board of Directors has instructed management to form a life insurance company, Physicians Life Insurance Company of Ohio (PLICO), and this will be operational as early as possible in 1978.

TREAT THE SYMPTOMS IN THE GERIATRIC PATIENT

APATHY • IRRITABILITY
FORGETFULNESS • CONFUSION



Cerebro-Nicin® CAPSULES

A GENTLE CEREBRAL STIMULANT & VASODILATOR FOR GERIATRIC PATIENTS

Each CEREBRO-NICIN capsule contains:
Pentylenetetrazole .....100 mg. • Nicotinic Acid ...100 mg.
Ascorbic Acid .....100 mg. • Thiamine HCl .....25 mg.
l-Glutamic Acid .....50 mg. • Niacinamide .....5 mg.
Riboflavin .....2 mg. • Pyridoxine HCl .....3 mg.
AVAILABLE: Bottles 100, 500, 1000
SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and abdominal cramps. The reaction is usually transient.
INDICATIONS: As a cerebral stimulant and vasodilator.
RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.
WARNING: Overdosage may cause muscle tremor and convulsions.
CONTRAINDICATIONS: Epilepsy or low convulsive threshold.
CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

Write for literature and samples . . .
BROWN THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057

(3) The PICO Board of Directors agreed in principle to authorize PICO management to assist the Kentucky Medical Association in forming its own insurance company and to sell PICO policies in Kentucky.
(4) As of November 11, 1977, PICO has 2500 primary and 600 excess policies in force with written premiums, including all property and casualty business, of over $14,000,000. Stock sales to this date exceed $7,500,000.

DEPARTMENT OF FEDERAL LEGISLATION & PUBLIC POLICY

Mr. Edgar reported informally on fraud and abuse legislation, medical education legislation and health planning legislation.

He also reported that the formation of Education as a separate Department outside of HEW appears to be gaining Presidential approval and active support.

DEPARTMENT OF STATE LEGISLATION

Mr. Mulgrew and Mr. Ayish reported for the Department of State Legislation.

When the State Legislature opens January 3, optometry legislation and certificate of need legislation will remain important issues.

It was reported that the first three regional legislative conferences have been held and the results have been received with enthusiasm. Future conferences will be scheduled as time permits.

FIELD SERVICE DEPARTMENT

Mr. Holcomb, in his year's summary, suggested more district meetings for general discussion to bring better understanding among the members, and recommended a program on the legislative process during the Annual Meeting at such times when the Reference Committee sessions do not interfere.

His recommendations were accepted for consideration.

COUNCILOR REPORTS

The Councilors reported on the activities in their districts.

LEGAL COUNSEL REPORT

After an extensive report from Mr. Pohlman, supplemented by remarks by Mr. Mulgrew, the Council voted to reaffirm its two-part policy, initially adopted at

(continued on page 96)



IMMEDIATE or **GRADUAL**

nicotinic acid therapy

IMMEDIATE RELEASE

LIPO-NICIN/100 mg.
Each blue tablet contains:
Nicotinic Acid .....100 mg.
Niacinamide ..... 75 mg.
Ascorbic Acid .....150 mg..
Thiamine HCL (B-1) .. 25 mg.
Riboflavin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6).. 10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500, 1000.

LIPO-NICIN/250 mg.
Each yellow tablet contains:
Nicotinic Acid . .....250 mg.
Niacinamide ..... 75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .. 25 mg.
Riboflavin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6).. 10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500, 1000.

GRADUAL RELEASE

LIPO-NICIN/300 mg.
Each time-release capsule contains:
Nicotinic Acid .....300 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (H-1) .. 25 mg.
Riboflavin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6).. 10 mg.
In a special base of prolonged therapeutic effect.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient. Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur. Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

BROWN THE BROWN PHARMACEUTICAL CO., INC. 2500 West Sixth Street, Los Angeles, California 90057
Write for Literature and Samples
REFER TO PDR

OHIO STATE MEDICAL ASSOCIATION

	01 Admin.	02 CME	03 Health Ed.	04 Field Serv.	05 Fiscal Mbrshp.	06 Gov. M Care
Journal	0	0	0	0	0	0
Salaries	$ 79,893.00	$ 60,139.04	$36,775.56	$44,412.50	$103,564.20	$56,429
Staff Expense	8,000.00	5,000.00	3,300.00	7,000.00	5,000.00	3,000
Pres. Exp. '77-78	5,200.00	0	0	0	0	0
'78-79	5,000.00	0	0	0	0	0
Pres. Elect '77-78	2,800.00	0	0	0	0	0
'78-79	2,000.00	0	0	0	0	0
Past. Pres.	2,000.00	0	0	0	0	0
Secy. Treas.	2,000.00	0	0	0	0	0
Council Expense	25,000.00	0	0	0	0	0
AMA Del/Alt Exp.	0	0	0	0	0	0
Committees	200.00	19,120.00	14,600.00	200.00	8,000.00	17,925
Annual Meeting	0	81,500.00	0	0	0	0
Building Expense	8,521.50	5,681.00	2,840.50	3,550.62	14,912.64	2,840
Car Lease	11,703.00	141.00	141.00	1,128.00	141.00	141
Council Dist. Conf.	6,000.00	0	0	0	0	0
Data Processing	0	0	0	0	100,000.00	0
Emergency Fund	1,300.00	1,170.00	1,170.00	1,170.00	1,170.00	1,170
Equipment Rental	2,295.77	3,043.23	1,521.62	1,521.62	6,086.44	1,521
Field Service	0	0	0	2,500.00	0	0
Insurance & Bonding	11,076.00	312.40	312.40	312.40	312.40	312
Interest	2,008.39	1,338.93	669.46	836.83	3,514.70	669
Legal Expense	35,000.00	0	0	0	0	0
Library	200.00	180.00	180.00	180.00	180.00	180
Meeting Expense	0	2,500.00	1,500.00	3,000.00	0	0
OSMAgram	0	0	0	0	0	0
Postage	3,172.76	4,205.75	2,102.87	2,102.87	8,411.47	2,102
Prof. Relations Acct.	756.50	680.85	680.85	680.85	680.85	680
Public Relations	0	0	0	0	0	0
Supplies: Misc.	358.39	475.08	237.54	237.54	950.16	237
Supplies: Office	2,408.00	3,192.00	1,596.00	1,596.00	6,384.00	1,596
Taxes: Payroll	2,242.98	3,576.10	1,763.85	1,860.65	5,988.18	1,890
Telephone & Telegraph	6,305.13	2,490.15	2,490.15	3,187.25	3,880.89	2,490
Depreciation	2,424.00	1,616.00	808.00	1,010.00	4,242.00	808
Furniture & Equipment	3,500.00	1,540.00	200.00	1,000.00	6,000.00	270
Mortgage Amort.	2,896.54	1,931.02	965.51	1,206.89	5,068.95	965
TOTALS	$234,261.96	$199,832.55	$73,855.31	$78,694.02	$284,487.88	$95,231
7% Cut-back	(10,805.83)	(9,778.55)	(2,595.58)	(2,399.71)	(12,664.64)	(2,716
ADJUSTED TOTALS	$223,456.13	$190,054.00	$71,259.73	$76,294.31	$271,823.24	$92,514

1978 BUDGET: DEPARTMENTAL ANALYSIS

07 ournal	08 Org. Serv.	09 Fed. Leg. Pub. Pol.	10 State Leg.	11 Commun.	Rental Area	1978 Budget
0.000.00	0	0	0	0	0	$ 120,000.00
9,760.48	$ 57,323.24	$ 51,651.36	$ 56,698.08	$40,149.40	0	626,796.08
3,000.00	2,500.00	3,500.00	15,000	4,000.00	0	59,300.00
0	0	0	0	0	0	5,200.00
0	0	0	0	0	0	5,000.00
0	0	0	0	0	0	2,800.00
0	0	0	0	0	0	2,000.00
0	0	0	0	0	0	2,000.00
0	0	0	0	0	0	2,000.00
0	0	0	0	0	0	25,000.00
0	36,970.00	0	0	0	0	36,970.00
0	1,050.00	3,000.00	1,610.00	300.00	0	66,005.00
0	0	0	0	0	0	81,500.00
6,391.12	4,970.87	3,550.62	6,391.12	3,550.62	7,811.37	71,012.48
141.00	141.00	141.00	141.00	141.00	0	14,100.00
0	0	0	0	0	0	6,000.00
0	0	0	0	0	0	100,000.00
1,170.00	1,170.00	1,170.00	1,170.00	1,170.00	0	13,000.00
2,295.77	2,295.77	1,521.62	2,295.77	2,295.77	0	26,695.00
0	0	0	0	0	0	2,500.00
312.40	312.40	312.40	312.40	312.40	0	14,200.00
1,506.29	1,171.56	836.83	1,506.29	836.83	1,841.02	16,736.59
350.00	0	0	35,000.00	0	0	70,350.00
180.00	180.00	180.00	180.00	180.00	0	2,000.00
0	0	5,698.00	0	0	0	12,698.00
0	0	17,000.00	0	0	0	17,000.00
3,172.76	3,172.76	2,102.87	3,172.76	3,172.76	0	36,892.50
680.85	680.85	680.85	680.85	680.85	0	7,565.00
0	0	0	0	30,000.00	0	30,000.00
358.39	358.39	237.54	358.39	358.39	0	4,167.35
2,408.00	2,408.00	1,596.00	2,408.00	2,408.00	0	28,000.00
2,558.05	2,582.25	1,860.65	2,993.65	2,364.45	0	29,681.71
2,836.96	2,836.96	2,836.96	2,836.96	2,490.15	0	34,681.71
1,818.00	1,414.00	1,010.00	1,818.00	1,010.00	2,222.00	20,200.00
2,000.00	1,254.00	1,000.00	1,200.00	1,700.00	0	19,664.00
2,172.40	1,689.65	1,206.89	2,172.40	1,206.89	2,655.16	24,137.81
93,112.47	$124,481.70	$101,093.59	$137,945.67	$98,327.51	$14,529.55	$1,635,853.23
10,734.64)	(4,701.09)	(3,460.96)	(5,687.33)	(4,072.47)	0	(69,616.93)
82,377.83	$119,780.61	$ 97,632.63	$132,258.34	$94,255.04	$14,529.55	$1,566,236.30

(Proceedings continued on page 98)

its meeting on April 28, 1976, with respect to the function and activity of the Medical Services Review Committee, as follows:

(1) non-participation at this time in the review of any disputes among physicians, patients and/or third parties, except those arising out of issues such as utilization of physician's services, medical necessity and appropriateness of medical care and similar complaints, and
(2) resumption of fee review activities when future legal and other developments make it appropriate to do so.

Mr. Pohlman also reported on the status of several pending lawsuits involving or of interest to the Association.

OHIO DIRECTOR OF HEALTH

Dr. Ackerman announced a hearing by the Ohio Public Health Council during February to establish rules governing Ohio's certificate of need program.

A proposed Cooperative Health Statistics System for Ohio was announced by Dr. Ackerman, who requested OSMA endorsement of this project, having to do with gathering data for health manpower planning. The Council agreed to study the matter and to consider in detail at its next meeting.

There being no further business the Council meeting was adjourned.

ATTEST: Hart F. Page, CAE
Executive Director

MOVING?

Notify *The Journal*
60 days in advance

Name_____

Street_____

City_____ State_____ Zip_____

Mail to:
Executive Editor
The Ohio State Medical Journal
600 S. High Street
Columbus, Ohio 43215



Cardilate® (erythrityl tetranitrate)
INDICATIONS For the prophylaxis and long-term treatment of patients with frequent or recurrent anginal pain and reduced exercise tolerance associated with angina pectoris, rather than for the treatment of the acute attack of angina pectoris, since its onset is somewhat slower than that of nitroglycerin.

PRECAUTIONS: As with other effective nitrites, some fall in blood pressure may occur with large doses

Caution should be observed in administering the drug to patients with a history of recent cerebral hemorrhage, because of the vasodilation which occurs in the area Although therapy permits more normal activity, the patient should not be allowed to misinterpret freedom from anginal attacks as a signal to drop all restrictions

SIDE EFFECTS No serious side effects have been reported In sublingual therapy, a tingling sensation (like that of nitroglycerin) may sometimes be noted at the point of tablet contact with the mucous membrane If objectionable, this may be mitigated by placing the tablet in the buccal pouch As with nitroglycerin or other effective nitrites, temporary vascular headache may occur during the first few days of therapy This can be controlled by temporary dosage reduction in order to allow adjustment of the cerebral hemodynamics to the initial marked cerebral vasodilation. These headaches usually disappear within one week of continuous therapy but may be minimized by the administration of analgesics.

Mild gastrointestinal disturbances occur occasionally with larger doses and may be controlled by reducing the dose temporarily

HOW SUPPLIED 10 mg chewable scored tablets, bottle of 100 Also 5, 10 and 15 mg oral/sublingual scored tablets in bottles of 100 10 mg oral/sublingual scored tablets also supplied in bottles of 1,000

Also available Cardilate®-P brand Erythrityl Tetranitrate with Phenobarbital* Tablets (Scored).
(*Warning – may be habit-forming)

Wellcome
Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709



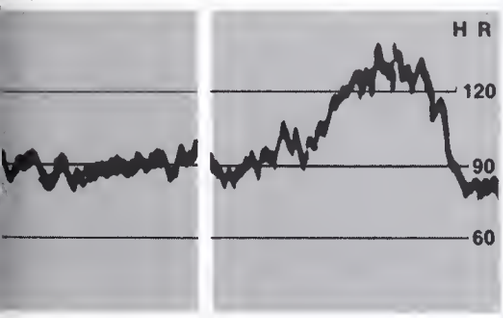
"**Our sex life is nil...**" A problem of the first magnitude to many post infarct patients and their mates...patients are often reluctant to broach the subject; physicians may frequently overlook its implications. This new 16mm film combines candid patient interviews with discussions by Drs. Herman Hellerstein, Thomas Hackett, Albert Kattus, Richard Stein, Carroll Witten and Lenore Zohman. Film and related monograph comprise 2 AAFP credit hours. To arrange viewing, write Burroughs Wellcome Co., Educational Services Department, Research Triangle Park, N.C. 27709 or contact your B.W. Co.® representative.

Sex and the heart patient:

A film every doctor should see.

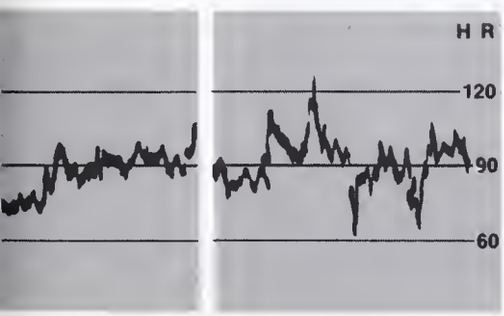
The energy cost of sex to the heart is relatively modest.
Over 80% of post-coronary patients can ultimately resume sexual activity without serious risk. Hellerstein and Freedman demonstrate that mean maximal heart rate during orgasm with spouse (as opposed to extra-marital sex) in 14 post-infarct patients is lower than that during usual occupational activity.

Representations below of actual EKG readings of an attorney, post MI, illustrate the point:



A. Working in office (about 90 beats/min)

B. Confrontation in judge's chamber (about 125 beats/min)



C. Pre-orgasm sex activity (about 90 beats/min)

D. Peaks at orgasm (120 beats/min)



Fear of pain greatest deterrent to post MI sex
In the multitude of MI patients with angina, pain is due to diminished coronary reserve and increased myocardial oxygen demand, precipitated by sex, other excitement and improper exercise. Anginal pain, however, can be relieved, and its recurrence mitigated.

Cardilate® (erythrityl tetranitrate) increases exercise tolerance.
Cardilate relieves anginal pain and prevents its recurrence, thereby allowing increased activity.
Commencing to work in as little as 2 to 5 minutes, Cardilate protects against recurrence of angina for at least 2 hours.

Available in both sublingual and chewable forms, Cardilate is a versatile, convenient agent to help make the angina patient's life more livable.

Cardilate®
(erythrityl tetranitrate)

OSMA Program a New Approach to Medical Liability Risk Management

The Ohio State Medical Association has entered into an agreement with a Denver, Colorado company which specializes in the creation and production of customized training systems. The firm, Jeppesen Sanderson, has developed a new concept in patient briefing, designed to minimize the possibility of a patient initiating a malpractice suit through comprehensive and documented patient education. This program is called Medical Patient Risks Education Program (MED PREP). (See advertisement on following page.)

The MED PREP Library is planned to consist of over 200 audiovisual presentations that will cover 16 specialties. Currently, materials are available in the obstetrics/gynecology and anesthesiology fields. These films and accompanying literature are designed to assist the physician in efficiently preparing the patient for a medical or surgical procedure and to help the patient comprehend the potential risks. The program is not designed or intended to replace physician-patient discussions, only to enhance and supplement these conversations.

Each film is 10 to 15 minutes in length and explains, in a straightforward-yet-personal fashion, the basic anatomy involved in the procedure, the treatment indicated, and the significant potential risks. Alternative methods of treatment are also discussed when appropriate.

After viewing the film, the patient is asked to read the accompanying briefing folder, which is a further reinforcement of the material contained in the audiovisual portion of the program. At the conclusion of the presentation, the patient signs a tear-off portion of the briefing folder, which is intended for retention in the physician's file as a permanent record that the patient has received a standardized explanation of the medical or surgical procedure to be performed.

MED PREP films are produced in 16 mm sound cartridge format designed to be viewed on an Audiscan™ projector. This cartridge contains both filmstrip and synchronized audio tape in a closed-loop system that never needs rewinding. After inserting the cartridge into the projector and pushing the start button, the program begins. When the program is finished, the projector shuts off automatically.

Using professionally executed photography, art, and narration, each program is directed to the layperson. When purchased through the Ohio State Medical Association, member physicians may buy each film and accompanying set of 50 patient-briefing folders for $75. Replacement briefing folders are priced at $8.75 per set of 50. (When purchased directly from Jeppesen Sanderson, the price for each film and accompanying set of 50 briefing folders is $95, and the replacement sets of patient briefing folders are $10.95.)

Comprehensive and documented patient education is an essential part of the solution to the professional liability dilemma. The Jeppesen Sanderson MED PREP program appears to meet this need: providing the patient information necessary to make a rational decision about pending medical therapy through a carefully planned and executed program which assists the physician in presenting and documenting his patient briefing.

For further information on the Medical Patient Risks Education Program, a valuable OSMA-membership service, contact the Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215, phone: 614/228-6971.

AMA Drug Abuse Program

The AMA Department of Mental Health is holding a regional drug abuse conference on March 31 and April 1, 1978 in Chicago. Entitled "The Physician and Drug Abuse Treatment," the program will be held at the Water Tower Hyatt Hotel. Participants will be physicians and other interested individuals from Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin. Category I continuing education credit will be given on an hour-for-hour basis. The registration fee is $50 for AMA members, medical society executives, and nonphysicians; $100 for nonmember physicians. For further information and registration forms contact: AMA Department of Mental Health, 535 North Dearborn Street, Chicago, Illinois 60610, phone: 312/751-6577.

OSMA House of Delegates Resolution Deadline Approaching

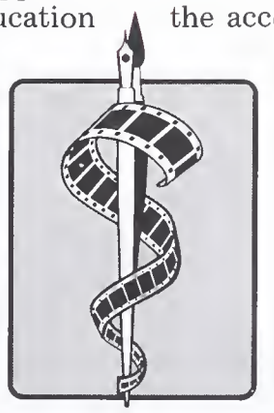
Delegates to the OSMA and county medical societies who plan to submit resolutions for consideration by the House of Delegates at the 1977 Annual Meeting should be guided by Chapter 4, Section 8, of the OSMA Bylaws entitled "Resolutions," which reads as follows:

Every resolution to be presented to the House of Delegates for action shall be filed with the Executive Director of the Association at least 60 days prior to the first day of the meeting at which action on such resolution is proposed to be taken; and promptly upon the filing of any such resolution the Executive Director shall prepare and transmit a copy thereof to each member of the House of Delegates. No resolution may be presented or introduced at any meeting of the House of Delegates unless the foregoing requirements for filing and transmittal shall have been complied with or unless such compliance shall have been waived by a Special Committee on Emergency Resolutions named to decide whether late submission was justified. This special committee shall consist of the chairmen of the several resolution committees. If a majority of the members of the Special Committee

(continued on page 102)

The Uninformed Patient– An Unnecessary Risk

Physicians are being sued often and successfully. Yet a large percentage of these liability suits have no medical or legal merit. We at Jeppesen Sanderson believe patient education that is comprehensive and also documented is an essential part of the solution to this unnecessary phenomenon.



MED PREP or Medical Patient Risks Education Program was developed for this purpose. The MED PREP Library is planned to consist of over 200 audiovisual presentations covering 16 specialties. A particular medical or surgical procedure is described in each film along with a number of significant potential risks and, in most instances, some possible alternative courses of treatment.

The MED PREP information is presented in easy-to-understand language and in a warm and personal manner. After viewing the film and being given the accompanying briefing folder, the patient signs the tear-off form which then can become a part of the physician's permanent file on that patient.

MED PREP provides sensitive and perceptive patient briefings and documents that the information has been received. MED PREP is being distributed by several medical societies and associations and is now available to physicians. For more information about MED PREP, contact Ohio State Medical Association, 600 South High Street, Columbus, Ohio, 43215 or call 614-228-6971.

JEPPESEN SANDERSON

8025 East 40th Avenue, Denver, Colorado 80207 • (303) 320-6070



News *(continued from page 100)*

on Emergency Resolutions vote favorably for waiving the filing and transmittal requirement, then such resolution shall be presented to the House of Delegates at its opening session. All resolutions presented subsequent to the 60-day filing date prior to the opening session of the House of Delegates shall be submitted by their sponsors to the committee no less than 12 hours prior to the opening session of the House of Delegates.

In accordance with this Section, resolutions must be submitted no later than March 9, 1978, for consideration at the May 1978 meeting of the House of Delegates.

Nominations for President-Elect Must Be Received by March 16

Attention is called to provisions in the Bylaws of the OSMA pertaining to the nomination and election of the president-elect at the OSMA Annual Meeting. The president-elect and other officers are elected by the House of Delegates, meetings of which will be held during the Annual Meeting in Dayton, May 6-10, 1978.

Nominations for president-elect are to be made 60 days in advance of the meeting, and information on nominations will be published in the April 1978 issue of *The Journal*. The only exceptions would exist if these provisions are waived by a two-thirds vote of the House of Delegates. The 60-day deadline is March 16, 1978.

The part of the OSMA Bylaws pertaining to this procedure is Chapter 5, Section 3, entitled "Nomination of President-Elect," which reads as follows:

Nominations for the office of President-Elect shall be made from the floor of the House of Delegates; provided, however, that only those candidates may be nominated whose names have been filed with the Executive Director at the time and in the manner hereinafter provided, unless compliance with such requirements shall be waived as hereinafter provided. The name of a candidate for the office of President-Elect must be filed with the Executive Director of the Association at least 60 days prior to the meeting of the House of Delegates at which the election is to take place. Promptly upon the filing of such candidate's name, the Executive Director shall prepare and transmit this information to each member of the House of Delegates. No nomination for President-Elect may be presented at any meeting of the House unless the foregoing requirements of filing and transmittal have been complied with or unless such compliance shall have been waived or dispensed with by a vote of at least two-thirds (⅔) of the delegates present at the opening session of such meeting. The Executive Director shall cause to be published in *The Journal* in advance of such meeting of the House of Delegates biographical information on all candidates meeting the requirements of filing and transmittal.

Many Foreign MDs Fail New Exam

Only 25 percent of foreign medical graduates who took the new Visa Qualifying Exam (VQE) last fall passed the test, according to the National Board of Medical Examiners. Under the new Health Manpower Act, foreign medical graduates must pass the VQE and an English-language proficiency test before receiving either an exchange-visitor or immigrant visa. Results showed that foreign physicians tended to perform better on the clinical test than on the basic science test. The examination is given once a year.

PICO Eliminates Premium Charge For Partnerships or Corporations

Effective immediately, the Physicians Insurance Company of Ohio (PICO) has eliminated its premium charges to medical partnerships or corporations for medical professional liability primary coverage, provided that all members of the partnership or corporation have individual primary policies with the company. This rate reduction is effective on new policies written and on the respective renewal dates of policies in force.

Joseph K. Gilmore, President of PICO, explained the action:

It has been standard procedure in the insurance industry to extend medical professional liability primary coverage to a partnership or corporation for a premium charge equal to 20 percent of the aggregate annual premiums of its members for their individual policies. We believe, based on a careful and extensive analysis, that we can extend this coverage for the premiums generated by the individual policies only.

Submit Record of Reregistration CME Hours as Soon as Complete

The Ohio State Medical Board urges every physician holding an Ohio license to submit his record of continuing medical education hours to the Board as soon as he has completed the 150 hours mandated for reregistration of medical license as of 1980. Complete information regarding the reregistration program, including a record form, may be found in the December 1976 (Vol. 72, No. 12) issue of *The Journal*. Questions and record forms should be directed to the Ohio State Medical Board, 180 East Broad Street, Columbus, Ohio 43215, phone: 614/466-3934.

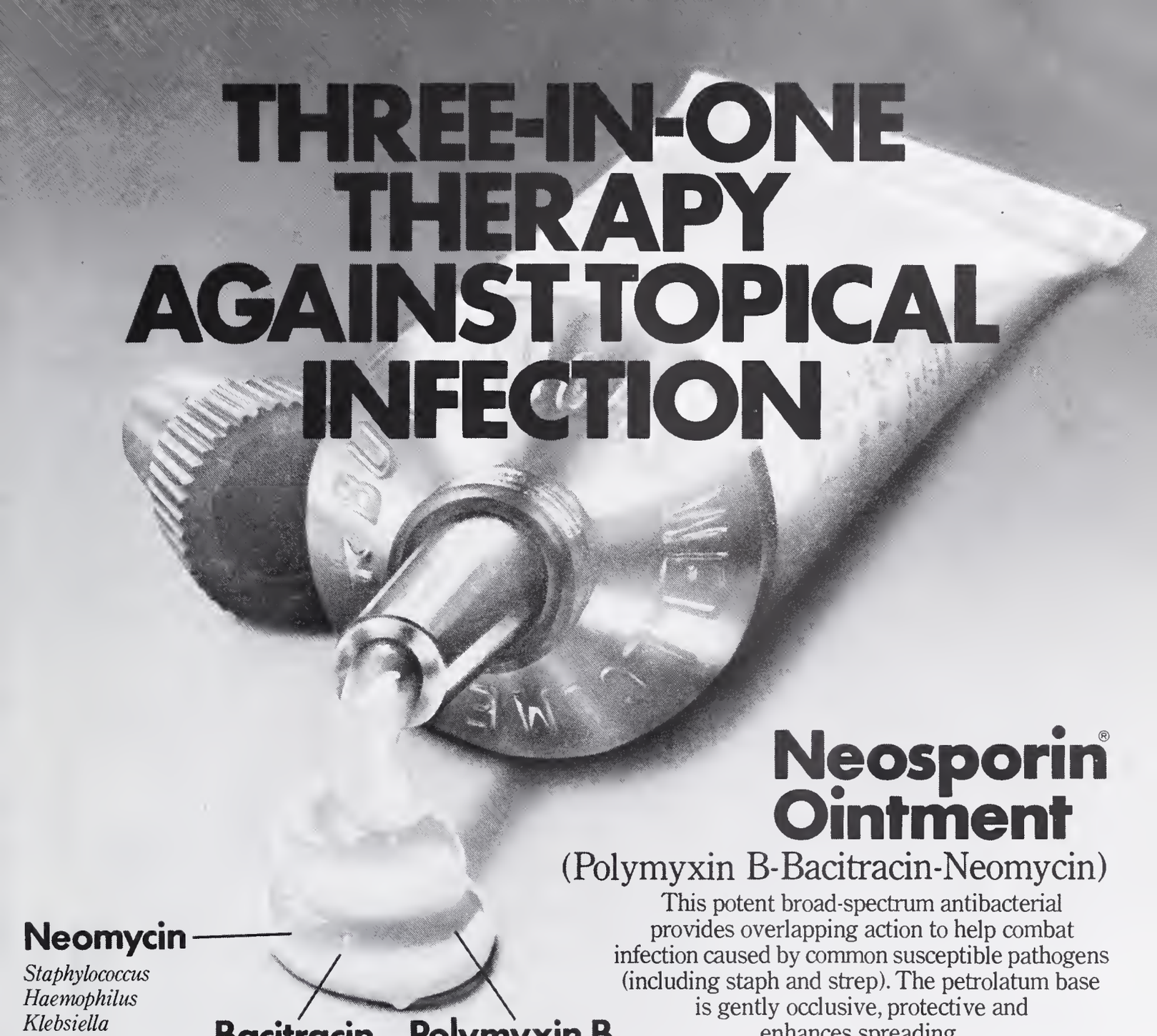
Central Ohio Hospitals Share Pharmacy Services

Grant Hospital, Columbus, has developed a system for sharing pharmacy services with small, rural hospitals, which enables those institutions to save money and to expand and to improve services to patients. Grant Regional Pharmacy Services (GRPS) is a nonprofit system, uniting five rural Ohio hospitals— Berger, Circleville; Lancaster-Fairfield, Lancaster; Hocking Valley Community, Logan; Mount Saint Mary, Nelsonville; and Pike County, Waverly— with Grant Hospital.

GRPS utilizes a contract approach for all aspects of pharmacy operations, including purchasing, in the six otherwise independent hospitals. Grant is responsible for management of all six pharmacies, along with recruiting, hiring, and training pharmacists and staff. Additionally, Grant negotiates contracts and purchases of drugs and supplies as a 1,000-bed hospital group, resulting in substantial quantity discounts.

Since the program's inception in April 1976, each of the smaller hospitals has experienced an increased gross margin between revenues and expenses, collectively estimated at more than $133,000 the first year. In addition, pharmacy services have been upgraded.

THREE-IN-ONE THERAPY AGAINST TOPICAL INFECTION



Neosporin® Ointment

(Polymyxin B-Bacitracin-Neomycin)

This potent broad-spectrum antibacterial provides overlapping action to help combat infection caused by common susceptible pathogens (including staph and strep). The petrolatum base is gently occlusive, protective and enhances spreading.

Neomycin
Staphylococcus
Haemophilus
Klebsiella
Aerobacter
Escherichia
Proteus
Corynebacterium
Streptococcus
Pneumococcus

Bacitracin
Staphylococcus
Corynebacterium
Streptococcus
Pneumococcus

Polymyxin B
Pseudomonas
Haemophilus
Klebsiella
Aerobacter
Escherichia

In vitro overlapping antibacterial action of Neosporin® Ointment (polymyxin B-bacitracin-neomycin).

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Neosporin® Ointment

(Polymyxin B-Bacitracin-Neomycin)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

COLBY PROCLAIMS WOMAN SUFFRAGE

Signs Certificate of Ratification at His Home Without Women Witnesses.

MILITANTS VEXED AT PRIVACY.

Wanted Movies of Ceremony, But Both Factions Are

WASHINGTON, Aug. 26, 1920—



Social Security Bill Is Signed; Gives Pensions to Aged, Jobl

Roosevelt Approves Message Intended to Benefit 30,000, Persons When States Adopt Cooperating Laws–He Cal the Measure 'Cornerstone' of His Economic Program.

WASHINGTON, Aug. 14, 1
The Social Security Bill, provi
a broad program of unemploy
insurance and old age pens
and counted upon to benefit
20,000,000 persons, became la
day when it was signed by P
dent Roosevelt in the presen
those chiefly responsible for
ting it through Co
Mr. Roosevelt cal
"the cor erstone
which is being
me s c mple
ri o

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved
today 94 to 0 and sen

TRUMAN CLOSES TED NATIONS CONFEREN ITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

SIGNE the Draf Ends Nov

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the



PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA
THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION
1155 FIFTEENTH ST., N. W. WASHINGTON, D. C. 20005

THE OHIO STATE Medical Association Continuing Education Programs

Editor's Note: *The following are Category I courses offered in Ohio. Items for this listing come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in dates, places, or time occur too late to be corrected before publication. Physicians interested in a course are urged to contact the sponsoring organization to confirm the information listed. Sponsoring organizations may list Category I courses by contacting the OSMA Department of Continuing Medical Education or The Journal. Notification 90 days prior to the course would be appreciated. Due to space limitations, announcements may be published only once.* **See previous issues of The Journal for additional courses.**—*L.A.J.*

February 1978

NUTRITION: PERSPECTIVES AND PROBLEMS IN EVERYDAY PRACTICE: February 17-18, Sheraton Westgate Inn, Toledo; sponsor: Medical College of Ohio; 12 credit hours: fee: $65 physicians, $35 RD or RN; contact: Howard S. Madigan, M.D., Associate Dean, Continuing Education, Medical College of Ohio, C.S. #10008, Toledo 43699, phone: 419/381-4237.

NEUROLOGY: February 22; Middletown Hospital, Middletown; 3 credit hours; fee: $35; contact: Office of CONMED, 231 Bethesda Avenue, Cincinnati 45267, phone: 513/872-5486.

March 1978

SURGICAL IMMUNOLOGY: March 2; St. Elizabeth Hospital Medical Center. Youngstown; 4 credit hours: contact: Rashid A. Abdu, M.D., Director of Education, Belmont and Park Avenues, Youngstown 45501, phone: 216/746-7211, ext. 202.

1978 OHIO INTERNATIONAL CONFERENCE ON DIAGNOSTIC MEDICINE: March 2-16, Portugal; sponsor: Ohio Academy of Family Physicians; 30 credit hours; fee: $100; contact: Glenn W. Pfister, M.D., Ohio Academy of Family Physicians, 4075 North High Street, Columbus 43214, phone: 614/267-7867.

HAZARDS OF CURRENT ANESTHESIA: March 21, 7:30 AM; Riverside Methodist Hospital, Columbus: 1 credit hour; contact: Mrs. Joyce Miller, Staff Secretary or Ms. Karen Saslaw, Education Coordinator. 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

STUMP THE EXPERT: March 21, 8:30 A.M.; Riverside Methodist Hospital, Columbus; 1 credit hour; contact: Mrs. Joyce Miller, Staff Secretary, or Ms. Karen Saslaw, Education Coordinator, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

CONTROVERSIES IN NEUROSURGERY: March 29-30; Cleveland Clinic Foundation, Cleveland; 12 credit hours; fee: $125, $65 physicians-in-training: contact: Penn G. Skillern, M.D., Center for CME. The Clevelad Clinic Educational Foundation, Cleveland 44106, phone: 216/444-5696.

13TH ANNUAL CANCER SYMPOSIUM: March 29-30; Akron City Hospital, Akron; 10 credit hours; fee: $50, $25 residents; contact: Mrs. Linda Kerlee, 525 E. Market Street, Akron 44309, phone: 216/375-3203.

TECHNIQUES OF NUTRITIONAL REHABILITATION IN HOSPITAL PATIENTS: March 31-April 1; Cleveland Clinic Foundation, Cleveland; 12 credit hours; contact: Penn G. Skillern, M.D., Center for CME, The Clevelad Clinic Educational Foundation, Cleveland 44106, phone: 216/444-5696.

April 1978

SPORTS MEDICINE: April 6-7, Cleveland Clinic Foundation, Cleveland; 12 credit hours; fee: $90, $45 students: contact: Center for CME, The Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

GAMES WE PLAY— RECREATIONAL SPORTS PROBLEMS: April 9, Sheraton-Columbus Hotel, Columbus; sponsor: Ohio Academy of Family Physicians; cosponsor: OSU-CCME and Ohio Osteopathic Association; 6 credit hours; contact: Mrs. Florence Landis, Ohio Academy of Family Physicians, 4075 North High Street, Columbus 43214, phone: 614/267-7867.

LIPID DISORDERS AND ABDOMINAL PAIN: April 11, 8:30 AM, Riverside Methodist Hospital, Columbus; 1 credit hour; contact: Mrs. Joyce Miller, Staff Secretary, or Ms. Karen Saslaw, Education Coordinator, 3535 Olentangy River Road, Columbus 43214, phone: 614/267-5428.

NEW CONCEPTS IN THE MANAGEMENT AND TREATMENT OF PANCREATITIS: April 11, 7:30 AM, Riverside Methodist Hospital, Columbus; 1 credit hour; contact: Mrs. Joyce Miller, Staff Secretary, or Ms. Karen Saslaw, Education Coordinator, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

SYMPOSIUM ON MALIGNANT MELANOMA: April 12; Cleveland Clinic Foundation, Cleveland; 6 credit hours; fee: $40, $20 students; contact: Center for CME, The Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

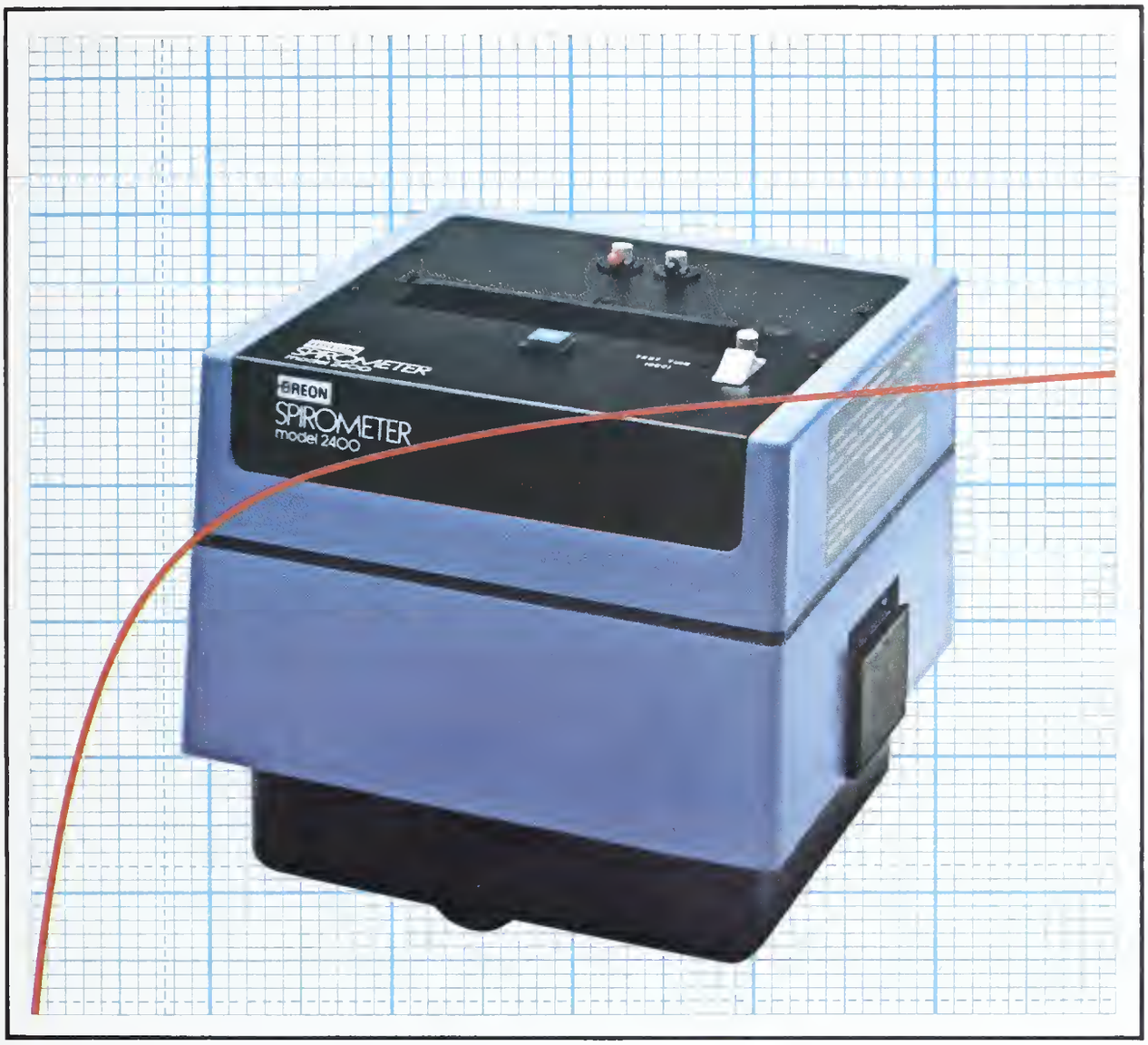
DIAGNOSTIC RADIOLOGY: April 13; sponsor: CONMED; 3 credit hours; fee: $15; contact: Office of CONMED, 231 Bethesda Avenue, Cincinnati 45267, phone: 513/872-5486.

CURRENT CONCEPTS IN SURGICAL PATHOLOGY: April 19-20, The Cleveland Clinic Foundation, Cleveland; 12 credit hours; fee: $100, $50 students; contact: Center for CME, The Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

May 1978

RADIOLOGY OF THE SPINE: May 5 and 6; Ramada Inn, Dayton; sponsor: Wright State University School of Medicine; 12¾ credit hours; fee: $100; contact: Arlene Polster, Program Coordinator, Department of Postgraduate Medicine, WSU School of Medicine, P.O. Box 927, Dayton 45401, phone: 513/429-3200, ext. 376.

SPIROMETRY MADE SIMPLE



Introducing the **BREON**
SPIROMETER
MODEL 2400

- Positive Displacement Direct Reading Spirometer
- Simple to Use
- Easy to Interpret

For more information send in this postage-paid card.

First Class
Permit No.
59720
New York, N.Y.
10016

BUSINESS REPLY MAIL
No postage necessary if mailed in the United States

Postage will be paid by:

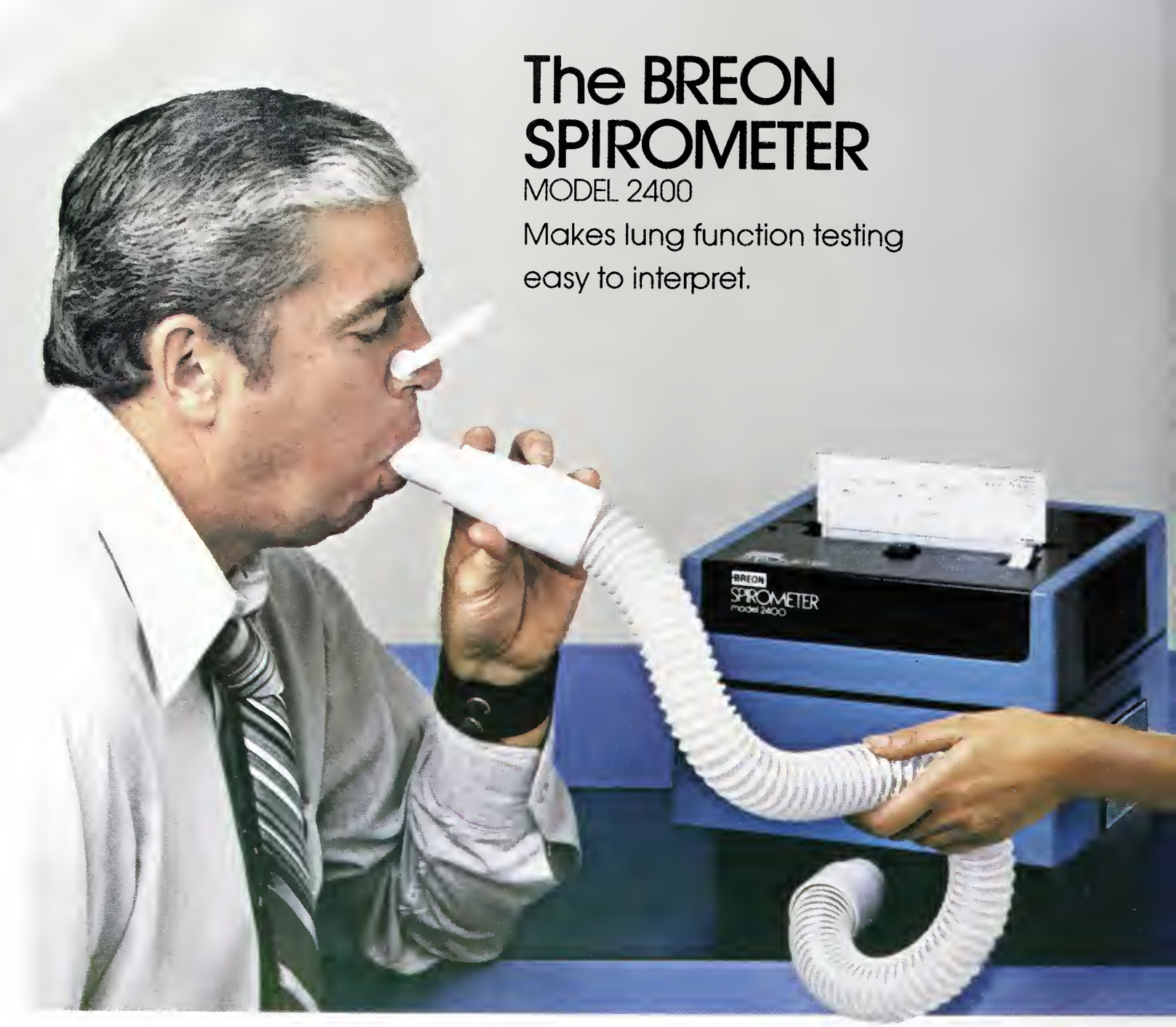
Breon Laboratories Inc.
90 Park Avenue
New York, N.Y. 10016

Attn: M. Trepicchio

The BREON SPIROMETER

MODEL 2400

Makes lung function testing easy to interpret.



- Provides a permanent record of results
- A single test provides most common and useful readings.
- ±1% accuracy at full scale
- Weighs less than 10 pounds
- Economical to use

I'd like to know more about office spirometry and the **Breon SPIROMETER Model 2400.**

☐ Please send me more literature.

☐ Please have your representative call.

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____

For more information send in this postage-paid card.

BREON

Breon Laboratories Inc.
90 Park Avenue
New York, N.Y. 10016

THE OHIO STATE Medical Association Clinical and Scientific

Fetal Alcohol Syndrome Metabolic Abnormalities

Arun K. Rawat, D.Sc.

Excessive alcohol drinking during pregnancy results in several injurious effects on the developing fetus. This condition is termed as "fetal alcohol syndrome" and is observed in both human and experimental models. The details of anatomic, physiologic, and neurologic abnormalities are reviewed.

RECENTLY, THE ILL EFFECTS of prolonged alcohol consumption during pregnancy on the developing fetus have been rediscovered.[1,2] This condition has been termed "fetal alcohol syndrome."[3,4] Fetal alcohol syndrome has been observed to manifest itself through the clinical occurrence of mental retardation, developmental delay in growth and certain physiologic and anatomic abnormalities associated with neurologic problems.[5,6]

Although the clinical and scientific findings made in this field over the last three to four years have reemphasized the ill effects of alcohol in pregnancy, Greek and Roman literature have spoken of it since ancient times. As early as 1621, Burton, in his *Anatomy of Melancholy,* quoted Aristotle's observations that "foolish and drunken and hairbrained women most often bring forth children like unto themselves morose and languid."[7] In England, immediately after the so-called Gin Epidemic of 1926, the College of Physicians reported to the Parliament that maternal drinking is a cause of weak, feeble, and distempered children.

In a critical review in 1899, Sullivan studied 120 female inebriates who bore 600 children.[8] He compared the mortality rates of the offspring of 21 drunken mothers, who bore 125 children, with mortality rates of the offspring of their nondrinking female relatives. The death rate among the children of inebriate mothers was about 2.5 times higher than that found among the other sober women relatives. Scientists of the 1800s and 1900s recognized the retardation in both human and animal species growing in the presence of maternal alcoholism.[9] Unfortunately, little attention had been given to this phenomenon subsequently.

Since the earlier description of major malformation among children, principally of the eyes, limbs, cardiac and palatal defects,[1,5] several other workers have provided additional data for cases which corroborate the initial description.[10] Although there is no single, unifying, observable feature which allows the distinction of the syndrome, growth retardation, microcephaly, short palpebral fissures, and physical malformation have been observed generally in the progeny of alcoholic mothers. There is little evidence to suggest that the syndrome is a consequence of malnutrition or that the genetic factors are responsible for it. There is direct evidence to show that alcohol readily crosses the blood-brain and placental barriers of the fetus. Alcohol passes from the maternal circulation to the fetus in approximately the same concentration as in the maternal blood.[11] In fact, alcohol also has been observed to appear in the maternal milk in about the same concentration as that of the maternal circulation.[6] The generalized nature of the changes observed in "fetal alcohol syndrome" suggested that this is a direct toxic effect of alcohol or its oxidation product, acetaldehyde. The present investigation was undertaken to document this hypothesis and to work out the precise pathogenic mechanisms. This study has attempted to offer explanations at molecular levels for the observed abnormalities in anatomy, physiology, neurology, and behavior of the offspring of alcoholic mothers. It was conducted with laboratory animals where the precise control of the nu-

Dr. Rawat, Toledo, is Director, Alcohol Research Center, and Associate Professor of Psychiatry and Biochemistry, Medical College of Ohio at Toledo.
Submitted June 14, 1977

tritional state of the pregnant animals could be maintained relatively easily.

Results and Discussion

Developmental Delay and Inhibition of the Formation of Proteins. — It has been observed that infants born to alcoholic mothers are small in length in comparison to weight.[5] Most affected infants are below the third percentile for weight, height, and head circumference.[5] The generalized prenatal and postnatal developmental delay has led us to investigate the formation of protein in the vital organs of the fetus and the newborn from the alcoholic mother. In the brain, proteins play an important role in intelligence, learning, and retention of memory, while in the heart and liver, proteins are an integral part of the heart muscle or liver tissue. A decrease in the formation (synthesis) of proteins in general would result in the retardation of growth. The observations recorded in Table 1 show that continuous alcohol drinking by pregnant rats led to a marked decrease in the formation of proteins in brain, liver, and heart. These findings also demonstrated that newborns suckling on ethanol-fed mothers were very susceptible, in their earlier days of development, to alcohol which may be coming through the mother's milk.[12]

Neurologic Problems and Abnormal Neurotransmitter Development. — The "fetal alcohol syndrome" is heralded at birth by an increased incidence of breech deliveries. The abnormalities of a central nervous system (CNS) development are indicated by the behavior of the infants. They exhibit tremulousness and fine-motor dysfunction. They suck poorly, are awake more, and sleep less than is usual for their age.[3] Perhaps the most critical aspect of the "fetal alcohol syndrome" is the failure on the part of the surviving infants to achieve normalcy in intelligence, motor-age estimate, and social quotient.[3] The older children from alcoholic mothers exhibit weak grasp, poor coordination, and tremulousness. Self-stimulating behavior, such as head banging and rocking, is observed often in these children.[3] Although sufficient data is not available on the pathologic findings in autopsies of infants with fetal alcohol syndrome, one fetal-alcohol-syndrome brain studied showed a serious disorientation of both neuronal and glia elements with incomplete cortical development.[5] The findings reported in Table 2 suggest that some of these neurologic abnormalities and the observed mental retardation may be the consequence of interference by alcohol in the normal development of neurotransmitters in the CNS. Alcohol which reaches the suckling newborn from the alcohol-drinking mother results in dramatic changes in brain acetylcholine, an excitatory neurotransmitter and GABA (gamma-aminobutyric acid), an inhibitory neurotransmitter (Table 2). Besides these changes, maternal alcohol consumption also results in decrease in brain dopamine, ribonucliec acid (RNA), deoxyribonucleic acid (DNA), and total brain weights.[13,14]

TABLE 1. Effect of Maternal Alcohol Drinking on Protein Formation in Brain, Liver, and Heart of Rat Fetuses and Newborns

Treatment	Protein Formation		
	Brain	Liver	Heart
Control-fetus	5.7	3.6	3.0
Alcohol-fetus	3.9	2.2	1.7
Control-neonate	8.0	5.0	4.0
Alcohol-neonate	3.4	3.3	2.8

Alcohol was fed for two weeks in liquid diet. Control group was given isocaloric sucrose. Protein formation was determined by aminoacid ^{14}C-leucine (p moles/min/mg protein). No. of observations in each group was 12.

TABLE 2. Effect of Maternal Alcohol Drinking on Brain Neurotransmitters of Rat Fetuses and Newborns

Treatment	Brain Neurotransmitters	
	Acetylcholine	GABA
Control-fetus	4.3	0.53
Alcohol-fetus	3.1	1.3
Control-neonate	8.0	2.0
Alcohol-neonate	6.0	2.8

Treatment same as in Table 1. Brain neurotransmitters expressed as n and μ moles per gram of brain tissue, respectively.

Conclusion

It can be said without the risk of overstatement that what we have observed so far regarding "fetal alcohol syndrome" may be just the "tip of the iceberg." Many more studies are required to determine the precise nature of the "fetal alcohol syndrome." Physicians working in delivery rooms, in maternal care and nursery situations should be alerted to the syndrome and should be advised and educated in monitoring maternal alcoholism. The measurement of blood and urine alcohol could be useful laboratory aids. Although "fetal alcohol syndrome" has been observed mostly in the infants of mothers who drink alcohol excessively, preliminary laboratory findings suggest that alcohol consumption equivalent to more than two drinks per day might have harmful effects.

References

1. Lemoine P, et al: Les enfants de parents alcoholiques: anomalies observees. A propas de 127 cas. *Quest Med* 25: 477-482, 1968.
2. Ferrier PE, Nicod I, Ferrier S: Fetal alcohol syndrome (letter). *Lancet* 2:1496, 1973.
3. Jones KL, Smith DW, Streissguth AP, et al: Outcome in offspring of chronic alcoholic women. *Lancet* 1:1076-1078, 1974.
4. Rosett HL, Quellette EM, Weiner L: Pilot prospective study of fetal alcohol snydrome at Boston City Hospital. *Ann NY Acad Sci* 273:118-122, 1976.
5. Jones KL, Smith DW, Hanson JW: The fetal alcohol syndrome: clinical delineation. *Ann NY Acad Sci* 273:130-137, 1976.
6. Rawat AK: Effect of maternal ethanol-consumption on fetal hepatic-metabolism in the rat. *Ann NY Acad Sci* 273:175-187, 1976.
7. Burton R (printed under pen name Democritus Junior):

The Anatomy of Melancholy (first edition 1621), London, William Tegg, 1866.
8. Sullivan WC: A note on the influence of maternal inebriety on the offspring. *J Mental Sci* **45**:489-503, 1899.
9. Sullivan WC: The children of the female drunkard. *Med Temp Rev* **3**:72, 1900.
10. Green HG: Infants of alcoholic mothers. *Am J Obstet Gynecol* **118**:713-716, 1974.
11. Waltman R, Iniquez ES: Plancental transfer of ethanol and its elimination at term. *Obstet Gynecol* **40**:180-185, 1972.
12. Rawat AK: Effect of maternal ethanol consumption on foetal and neonatal rat hepatic protein synthesis. *Biochem J* **160**:653-661, 1976.
13. Rawat AK: Effects of maternal ethanol consumption on the fetal and neonatal cerebral neurotransmitters, in The Role of Acetaldehyde in the Actions of Ethanol (Lindros and Eriksson, eds), *Finnish Foundation for Alcohol Studies* **23**:159-176, 1975.
14. Rawat AK: Ribosomal protein synthesis in the fetal and neonatal rat brain as influenced by maternal ethanol consumption. *Res Commun Chem Pathol Pharmacol* **12**: 723-732, 1975.

THE WENDT-BRISTOL COMPANY
1159 DUBLIN ROAD
COLUMBUS, OHIO 43215
614/486-9411

MEDICAL/SURGICAL PRODUCTS
LABORATORY PRODUCTS
SPECIALTY PRODUCTS
PHARMACEUTICALS
PATIENT AIDS
INSTRUMENTS
FURNITURE

Harding Hospital

ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

MEMBER BLUE CROSS OF CENTRAL OHIO

ADMISSION AND PRACTICES CONDUCTED WITHOUT REGARD TO RACE, CREED, OR NATIONAL ORIGIN

Offering a Full Range of Psychiatric Services

★ Inpatient Services for 120
★ Individual and Group Psychotherapy
★ Professional Adjunctive Therapy
★ Family Therapy
★ Special Care for the Disturbed Patient
★ Day Treatment for Adults and Adolescents
★ Halfway House
★ Family Care
★ Outpatient Treatment
★ Consultation and Evaluation
★ Special Program for Adolescents, Including School

For further information, call (614) 885-5381

George T. Harding, Jr., M.D.
Medical Director

Donald L Hanson
Administrator

445 East Granville Road
Worthington, Ohio 43085

There is a better way to do it... You can find it!

Two New Books Now Available -

PERSONNEL POLICIES AND PROCEDURES FOR THE MEDICAL OFFICE

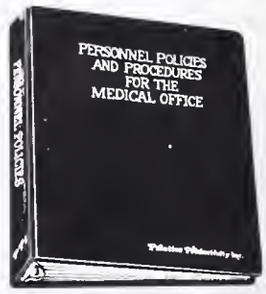
Do you have personnel policies? Are they written? Are they up to date? Do they provide a clear, concise, competitive statement of what you offer and what you expect from your employees? Are your policies within the guidelines of recent legislation?

- Tells the employee what to expect on these important topics:

Working hours	Personal appearance	Vacation	Outside employment
Holidays	Personal phone calls	Housekeeping	Personal medical care
Smoking	Civic responsibilities	Parking	Compassionate leave

- Reviews policy topics for the manager in depth.
- Prewords sample policies for you on 23 topics.
- Makes you aware of many employer obligations such as:

Sick leave	Medical &	Salary	Summary dismissal
Personal days	dental appointments	Discipline	Other benefits
Probation	Performance review	Termination	Leave of absence



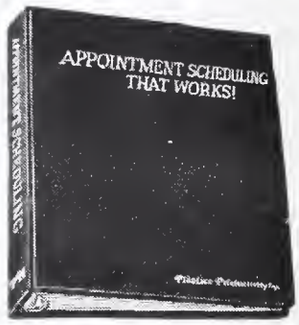
AN EASY WAY TO WRITE PERSONNEL POLICIES!

*

APPOINTMENT SCHEDULING THAT WORKS!

A course in appointment scheduling that enables your medical assistant to rebuild your scheduling system – according to the way you work.

- Your appointment employee learns about your real problems as she explores the improvements.
- The resulting schedule is custom designed for your specialty – the way you do things.
- Respects the patient's time. Keeps him from waiting more time than is reasonable - (usually 20 - 30 minutes maximum).
- Begin getting home on time.
- The workbook becomes a portfolio for continued improvement in future years.
- A simplified "Systems Analysis" approach to an age old problem.



A NEW APPOINTMENT SCHEDULE FOR YOU!

Practice Productivity Inc. **Management Consultants to Physicians**

Please send:

_____ copies of Personnel Policies and Procedures For the Medical Office at $24.50 + $1.80 for shipping and handling:Total $26.30.

_____ copies of Appointment Scheduling That Works! at $14.95 + $1.60 for shipping and handling: Total $16.55.

Send to:

Name _____ Telephone ( ) _____

Practice Name _____ Specialty _____

Address _____ No. of Doctors _____

City _____ State _____ Zip _____ No. of Employees _____

Bank Americard or Master Charge No. _____ Expiration Date ____/____Signature _____

Allow 2 - 3 weeks for delivery. Make check payable and send to:

PRACTICE PRODUCTIVITY INC., 2000 Clearview Avenue, Atlanta, Georgia 30340 (404) 455-7344

A Young Physician Looks at the Future of Sports Medicine

Joseph A. Butts, M.D.

In the future, the athletic community will consist of increasing numbers of athletes on the recreational, amateur, and professional levels. This will mean an ever-increasing number of sporting injuries. From time to time, almost every physician finds himself treating an injury which occurred during a sporting activity and, therefore, he is practicing in the area of sports medicine.

I FEEL HONORED to have been invited to participate in this afternoon devoted to sports medicine. I must admit I was somewhat unsure of my ability to compile a speech on the future of sports medicine. It is not a subject that can be researched at the library. As a result, most of this talk is based on my experiences and thoughts about sports medicine, as well as those of many of my close friends involved in the field of sports medicine throughout all areas of the United States.

It would indeed be a much simpler task to discuss the future of sports medicine if we knew what the future held for sports in this country. It is apparent to most people that as Americans have more and more free time, they will be devoting more and more time to spectator sports. To an even greater extent, they will be devoting more time to unorganized or locally organized sporting activities. This trend has been quite evident in the past few years; undoubtedly, it will continue in the future. Thus, there will be more people enjoying sports; and, as an unfortunate conclusion, there will be more sports injuries sustained by the recreational athletes.

I think the future of collegiate and professional sports is much more difficult to foresee. There is no doubt that athletics will continue at this level; the question is what the emphasis of the various sports will be. As many of the professional sports are encountering financial difficulties, it is difficult to determine how finances might change the picture of professional sports over the next ten years.

Collegiate athletics also are running into financial problems. Of equal importance to finances in the future of collegiate athletics, is an increasing undercurrent on today's university campuses that is attempting to attack the entire collegiate sport structure. No doubt major changes in the structure of collegiate athletics will occur over the next decade. I do not feel these changes will de-emphasize the so-called major sports, but rather will increase the emphasis on nonrevenue and women's sports.

So the future athletic community will consist of ever-increasing numbers of athletes on the recreational, amateur, and professional levels. This means an increase in the number of sporting injuries, most of which will be at the recreational level.

I should like to define a couple of the terms I have been using rather freely. The first is *sports medicine,* which I feel is best defined as the care given to any injury sustained by an athlete. The second term is *athlete.* To me, an athlete is any person participating in a sporting activity; the boys and girls who gather at the vacant corner lot for a game of tag football, softball, or soccer; the man or woman who gets out on Saturday morning for a round of golf or a set of tennis; or the professional athlete playing at Wimbleton, in the Super Bowl, or in the World Series. You will note from these definitions that I consider sports medicine to encompass a very broad area that potentially affects the vast majority of the people in this country. This is not to imply that I do not recognize the subspecialty of sports medicine. Later in this discussion, I shall make a distinction between sports medicine in the broad sense, as described by the preceding definitions, and the subspecialty of sports medicine.

Now, which physicians in our community are involved in sports medicine? I am sure we all agree that the physician for the high school or the college team undoubtedly is as involved in sports medicine as are the physicians for the many professional teams. However, I

Presented before the Section on General Practice and Sports Medicine at the Annual Meeting of The Ohio State Medical Association in Columbus, May 17, 1977.

Dr. Butts, Resident in Orthopedic Surgery, Children's, Riverside Methodist, and The Ohio State University Hospitals; and Sports Medicine Rotation, The Ohio State University Athletic Department.

Submitted July 19, 1977.

feel that any physician who sees patients sees sports injuries and, therefore, is involved in sports medicine! How many physicians have never treated a sprained ankle, a twisted knee, or a sore back that was the result of some sandlot game or an afternoon on the tennis court? Almost every family practitioner, internist, pediatrician, orthopedic surgeon, general surgeon, in fact, almost every physician occasionally finds himself treating an injury that occurred during a sporting activity and thus, he is in the area of sports medicine.

Is there any reason why we as physicians should not be giving the recreational athlete essentially the same care that the professional athlete receives? I am not saying that we need a sports medicine specialist in every neighborhood. What I am saying is that, in most cases, the recreational athlete enjoys his sports activity as much as — if not more than — the professional athlete. The fact that the recreational athlete is not making a large salary and is not in the limelight for his athletic ability is no excuse for us not diagnosing and treating his injuries so that he can return to his recreational sport, if possible. It really is sad to hear of all the people who had to give up a sporting activity they enjoyed very much due to an injury which, if properly diagnosed or more aggressively treated, could have resulted in sufficient recovery to allow the person to return to his game of tennis or softball. Many persons use recreational sports as an outlet or a means of relaxing and relieving tensions. So, it is essential to our patients' well-being — mental as well as physical — that we return as many of them as possible to their pre-injury activities.

The Challenge of Sports Medicine

This brings us to what I consider the real challenge of sports medicine: when to allow the athlete to return to competition. This is not quite as important on the recreational level as on the collegiate and professional levels, where it is essential that the athlete return to competition as soon as possible. On the recreational level, we can be more conservative in our decision on when to allow the local grocer to return to his golf game; but this is not to imply that we should not be aggressive in our treatment of the grocer's sports injury. Most athletes in organized sports are so anxious to get back to their particular sport that the physician sometimes has to literally "tie them down" to keep them from returning to activity too soon. This is one of the major reasons I enjoy working with athletes — they want to get well so fast they can "almost taste it." Without a doubt, the patient's welfare is our goal so we do not want him to resume activity so soon that he is exposed unnecessarily to an increased risk of injury; neither do we want to keep him from participating any longer than absolutely necessary. Doing so affects the athlete's mental well-being; many athletes need to be participating. So the real challenge of sports medicine is to find the "middle of the road" wherein the physician does not allow the athlete to return to competition too early but does not keep him inactive any longer than necessary.

The future structure of sports medicine in this country will not differ much from that of the present time. Basically, sports medicine is composed of two levels of involvement: the primary care level and the specialty level.

The Primary Care Level

The primary care level is composed of the thousands of physicians who see and care for the everyday sports injuries. This group includes almost every practicing physician. Without a doubt, this group of physicians cares for the vast majority of sports injuries. This level of the sports medicine structure will be our greatest challenge in the future. Many physicians have practically no knowledge of sports medicine. I am not implying that *every* physician — or even *most* physicians — should have an extensive background in sports medicine. However, I do feel that the primary care physicians who see and treat most sports injuries should have an adequate knowledge of musculoskeletal and other sporting injuries in order to properly diagnose and treat the minor or moderate sports injuries and to recognize those injuries that should be referred to a sports medicine specialist. Let us consider congestive heart failure (CHF). We all know how to recognize and properly treat a mild, uncomplicated case of CHF, yet we realize that we will see severe or complicated cases that will require the skills of a cardiologist. Should we not strive for the same goal in the area of sports injuries, ie, not only the ability to recognize and treat the mild injuries but also to recognize the severe or complicated injuries that will require the expertise of a sports medicine specialist to properly insure our patient's well-being? I realize that we are far behind in the area of an adequate primary care level of our sports medicine program, and I feel our major emphasis in the future must be to properly educate the primary care physician in the fundamentals of sports medicine.

The Specialty Level

This level of sports medicine is composed of physicians who spend all, or a significant amount, of their time caring for sports injuries. These physicians have a special interest in the care of the severe or complicated sports injury. Many of these physicians have special training and/or extensive backgrounds in the area of sports medicine. In the last few years, it has become quite popular to specialize in the area of sports medicine; I feel this trend will continue in the future. Most physicians specializing in sports medicine are associated with some professional or collegiate athletic team, a level of athletic competition in which it is essential that the athlete be returned to his sport as soon as possible. I do not see any problem in the future with finding an adequate number of physicians at this level. Our goal for the future for this level is to develop better modes of therapy and to improve repair and reconstructive pro-

cedures that will enable us to rehabilitate the athlete to a more complete level.

The manner in which the primary care and specialty care levels function together will be an influential factor in the success of the delivery of good medical care to the athlete in the future. Obviously, it is impossible for the sports medicine specialist to see every sports-related injury. The ideal structure for sports medicine is that the primary care level cares for the vast majority of injuries and refers the severe or complicated injuries to a physician at the specialty level (in much the same way as we care for other medical problems such as CHF).

Another fairly recent development in the area of sports medicine is the sports medicine clinic. These clinics have become increasingly popular in the last several years, and I am sure they will continue to spring up in more and more areas of the country in the future. These centers are a real "plus" to the field of sports medicine because, in addition to sports medicine specialists, they include such valuable allied medical personnel as physical therapists and athletic trainers. These various disciplines working together provide the potential for fully rehabilitating the athlete, which is one of the major goals of sports medicine.

Let me digress here to make one point clear. Thus far, my discussion on the future of sports medicine has been devoted primarily to what our aims should be regarding the care of sports injuries once they have occurred. The point I should like to stress at this time is that the ultimate goal of sports medicine is to *prevent* sports injuries! Although we can never fully achieve this goal, it is one that we must continue to strive for, both now and in the future. At times during a practice session or a game, I get bored; but I enjoy this boredome because it means there are no injuries and the athletes are healthy. This is our ultimate goal: a healthy athlete!

The Need for Physicians in Sports Medicine

Currently, one of the most pressing needs in the area of sports medicine is proper care for athletes at the high school and small college levels. We must strive to provide better care for our young men and women who participate at these levels. Although ideal, it would be unrealistic for each high school and college to have a team physician who could attend most practice sessions and all of the games. However, to strive for each school to have ready access to an interested and knowledgeable physician does not seem unrealistic. These physicians need not be sports medicine specialists — just physicians who are interested and willing to devote some of their time to the local athletic community.

Though we cannot expect every high school and college to have a physician at the practice sessions, I do think it is very reasonable for us to strive to have a qualified athletic trainer on the staff in these schools. I realize that such a goal cannot be attained overnight for two apparent reasons: the lack of an adequate supply of qualified athletic trainers and the growing financial problems faced by most schools. However, we cannot keep evading the problem; it will take several years to accomplish this goal, whether we start now or wait ten years. The sooner we start, the sooner we will reach the goal. The goal is a challenging one, but it is one that we physicians interested in the proper care of sports injuries should be interested in attaining. There is no question that the presence of qualified athletic trainers would encourage more physicians to devote time to their local high or college athletic programs.

One area that has been greatly neglected in the past but is destined to play a large role in the future of sports medicine is the role of the female physician in sports medicine. In the past, sports medicine has been predominately a male area. However, there has been a tremendous increase in the number of women participating in sports and an increased emphasis on the female sports program at the high school, college, and professional levels in recent years. As we all know, patients fare much better when they can relate and identify with their physician. Is there any reason why we should not expect, in fact strive, to interest more female physicians in sports medicine? Believe me, the interest in sports medicine is present in many of the young women now entering the field of medicine; all we need do is tap that interest.

There are two basic ways we can increase the number of physicians who are knowledgeable and participating in the area of sports medicine. First, we need to expose the young physician to sports medicine early in his career. Second, we must interest, educate, and reeducate the physician already in the community in the fundamentals of sports medicine.

I feel it is extremely important to interest the young physician in sports medicine early so that he can devote time to the local athletic program early in his career. A physician often is not approached about being the high school team physician until he is so busy with his practice that he cannot find the time. By exposing the young physician to sports medicine early in his career, he can work the local high school teams into his schedule before his regular practice consumes all of his time.

Here at The Ohio State University, we have made some advances toward exposing the young physicians to sports medicine early in their medical training. It is something that can be done at any medical school in the country. For the past three years, I have organized a sports medicine seminar for the medical students. The seminar each summer consisted of seven one-hour lectures, one night a week, for interested medical students, entirely on a voluntary basis. Each lecture was on a fundamental sports medicine subject and was given by various local physicians interested in sports medicine. The first summer, the average attendance was 65 students per session, which is an excellent average considering the students had to give up an evening of study. The attendance has fallen off somewhat the last two years, but I feel that if it only gives us one more high school team physician, it is well worthwhile, not to mention all the other medical

students who at least were exposed to some of the basics of sports medicine. It also is interesting to note that approximately 15 percent of the students attending the seminar were female medical students. However, I feel that these seminars will result in many more than one high school team physician. Many students who attended the session have approached me for more details on sports medicine and the requirements for being a team physician for a local high school. I would estimate that at least 20 to 25 students have told me they plan to approach their local high schools about being a team physician as soon as they begin their practice. I think this program will be quite productive here at Ohio State and one that I would like to see instituted at the other medical schools in Ohio and throughout the country.

Attracting the Practicing Physician

Now we come to the difficult question of how to interest, educate, and reeducate the physicians already in practice in the area of sports medicine. Obviously, the only answer is the use of continuing education courses and publications. I realize the medical community already is swamped with continuing education courses and reading. But how can we justify not educating the practicing physician in the rudiments of sports medicine when we consider the tremendous number of sports injuries sustained each year by recreational athletes who depend on their primary care physician to care for these injuries.

I should like to see several regional seminars conducted throughout the state each year and devoted to the more common sports injuries and their care. I also feel it would be quite appropriate for the various specialty groups and medical societies to include some discussion of a sports medicine topic at their meetings and conventions. There are few diseases, other than the common cold and influenza, that might affect more of our patient population than such sports-related injuries as ankle sprains.

In addition, I should like to see a periodic newsletter published perhaps as a joint effort on the part of the Ohio State Medical Association and the Ohio High School Athletic Association. Each issue of the newsletter would cover a certain sports injury, its diagnosis, and the proper medical care for it.

Conclusion

I have covered a lot of material, looked into my crystal ball, and made some suggestions. I do not know what the future of sports medicine will be. But I do feel that we physicians and all other persons interested in delivering the best possible care to the athlete — from the sandlot to the Super Bowl — must decide the goals we want to achieve in sports medicine in the next 10, 20, or 30 years and then do our utmost to reach them. We cannot sit back and let the current take us; we must define our objectives and work to achieve them.

★
Specialized Service
IN
PROFESSIONAL LIABILITY INSURANCE
is a high mark of distinction
THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA
OHIO OFFICES:
CINCINNATI: Room 700, 3333 Vine Street, (513) 751-0657, L. A. Flaherty
CLEVELAND: Suite 106, 23360 Chagrin Boulevard, Beachwood 44122, (216) 464-9950
A. C. Spath, Jr., R. A. Zimmerman
COLUMBUS: 1989 West 5th Ave., (614) 486-3939, J. E. Hansel
TOLEDO: 1011 Sandusky St., Suite H, P.O. Box 331, Perrysburg 43551, (419) 874-8080, R. E. Stallter

"Revelation of a second death, and new animal studies, indicate Laetrile can cause fatal poisoning...Georgia researchers will test laser beams for arthritis treatment...In Alabama, a vaccine for protection against dental caries is being studied...New York and Swedish clinicians unveil two noninvasive screening methods for detection of breast cancer..."

Important things are happening that you should know about right away. You'll find them on your desk every two weeks in Medical World News, the newsmagazine of medicine.

Read this one first.

medical world news

A McGraw-Hill publication



THE OHIO STATE Medical Association Cancer Education Series*

Acute Leukemia of Childhood and Adolescence

Samuel Gross, M.D.
William I. Staples, M.D.

ACUTE LEUKEMIA is characterized by the presence of immature and abnormal hematopoietic cells (blasts) in the bone marrow and peripheral blood, the proliferation and/or accumulation of which replaces and disrupts normal marrow architecture and a host of other tissues. The disease has an attack rate of 4.5 to 5.0/100,000/year with a peak incidence between 3 and 7 years of age. Acute leukemia is the major cause of all malignant deaths, and is the second leading killer of children in the first decade of life, being exceeded only by accidents. The two major cell types of acute leukemia are: lymphoblastic (ALL) and myeloblastic (AML). During the first six months of life, the latter predominates, but 90 percent of childhood leukemia is lymphoblastic.

Clinical Features

The symptomatology is variable and relates directly to the degree of anemia, thrombocytopenia, and granulocytopenia. Anemia occurs in about 80 percent of patients and is a result of bleeding due to thrombocytopenia and erythroid hypoplasia secondary to marrow replacement. Bleeding manisfestations are common due to thrombocytopenia, and serious hemorrhagic phenomena involving the central nervous system occur commonly in patients with marked leukocytosis and thrombocytopenia. Virtually all patients exhibit profound granulocytopenia which, in part, accounts for the frequency of fever in this disorder. The disease may be heralded by a "flu-like" syndrome characterized by anorexia, headache, muscle pain, and repeated febrile episodes. Bone pain occurs commonly and may mimic the arthralgia of rheumatic disorders. Prominent lymphadenopathy and hepatosplenomegaly occur in approximately 30 percent of patients.

Prognostic Factors

ALL.— Data derived from the Children's Cancer Study Group recognize two criteria of major prognostic significance: white blood cell count and age at diagnosis. Children in whom the diagnosis is established between the age 3 to 7 years with initial white blood cell counts less than 10,000 per cu mm have an 85-percent chance of surviving 48 months. The least favorable prognostic indicator at any age is a white blood count greater than 50,000 per cu mm at the time of presentation.

AML.— The median disease-free survival is 12 months for AML although patients between 2 and 5 years of age with initial white blood cell counts less than 20,000 per cu mm at onset have a better prognosis. In general, the prognosis in AML is worse than the prognosis for any patient with acute lymphoblastic leukemia.

Therapy

ALL.— It is possible to induce a complete remission characterized by normal blood values, a normal physical examination, and less than 5 percent blast cells in bone marrow in approximately 93 percent of all patients by using a combination of prednisone, vincristine, and L-asparaginase. Residual or potential disease in sanctuaries such as the central nervous system is not amenable to systemic therapy and is treated prophylactically with cranial irradiation and intrathecal methotrexate. Following remission induction, maintenance therapy is given to provide an opportunity for prolonged survival. In the low-risk group, with the most favorable prognosis, monthly injections of vincristine and prednisone are given in combination with weekly administration of methotrexate and daily administration of 6-mercaptopurine. In the less-favorable prognostic group, additional drug regi-

Dr. Gross, Cleveland, Director, Pediatric Hematology-Oncology, Rainbow Babies and Childrens Hospital; and Professor of Pediatrics, Case Western Reserve University School of Medicine.
Dr. Staples, Cleveland, Associate Pediatrician, University Hospitals and Cleveland Metropolitan General Hospital; and Associate Professor of Pediatrics, Case Western Reserve School of Medicine.
Submitted October 7, 1977.

The Journal is pleased to publish this series through the cooperation of the OSMA Committee on Cancer and the American Cancer Society, Ohio Division Inc.

mens, including adriamycin, cyclophosphamide, cytosine arabinoside, and high-dose methotrexate are used to prevent recurrence.

AML.— Cell-cycle-active agents, including vincristine, daunomycin, cytosine arabinoside, and 5-azacytidine, will induce a remission in 80 percent to 85 percent of patients with acute myeloblastic leukemia. Drugs useful in remission induction are often combined with thioguanine for remission maintenance. Immunotherapy with BCG vaccine or BCG and allogenic AML cells has not provided a clear-cut increase in survival, compared with chemotherapy alone. Bone marrow transplantation is not a proved or readily available form of treatment for either ALL or AML although many institutions are endeavoring to carry out such studies.

Complications

The major complication of acute leukemia is infection which is a result of bone marrow and immune system depression. Infections with gram-positive organisms are seen frequently at the onset of the disease, whereas infections due to gram-negative organisms predominate during the latter stages. Pneumocystis carinii and viral infections occur with increased frequency as a result of suppression of cell-mediated immunity. Adjustments in the dosage of antileukemic agents, the use of appropriate antimicrobial agents and granulocyte transfusions usually control the majority of bacterial infections. Recent developments in antiviral drug research offers hope that these types of infections may be more amenable to treatment.

Psychosocial Support

Once the diagnosis is established, emotional support for the patients and their families must be provided. The treatment protocols which provide the best opportunity for control of acute leukemia are complex and time-consuming, making it difficult for the specialist to deal with the many psychosocial problems of the patient. Accordingly, the family physician, pediatrician, nurse practitioner, and social workers have become an integral part of the treatment team and must provide effective support in the areas of family counseling, financial aid, school and home adjustment, and rehabilitation.

The incidence of remission induction and disease-free intervals in childhood and adolescent acute lymphoblastic leukemia has improved dramatically during the past 20 years; some patients have lived long enough to be considered cured of their disease. Presently available treatment and a multidisciplinary approach has improved the control of acute leukemia and the quality of life in the majority of patients. There is ample reason to believe that the treatment programs currently used to produce this improvement in prognosis will be obsolete in the next 20 years. Continuing research in basic and clinical science will ultimately provide therapeutic programs that make the concept of cure less ephemeral than it is at present.



The All-Important Goal...

proper insurance protection for yourself — and family.

How to make that goal? Take direct aim on these excellent insurance plans sponsored by the OSMA. As the administrator, we'll be happy to help.

1. Disability Income Protection — The coverage that assures you a weekly income when you're disabled by an accident or illness. Select benefits up to $500 weekly.

2. Term Life Insurance — Quality life insurance with maximum coverage of $100,000. Membership or corporate plan available. A 43% dividend was paid last year. (Dividends are not guaranteed.)

We're happy to be on your team! For more information, contact:

TURNER AND SHEPARD INC.

17 South High Street Columbus, Ohio 43215 Phone (614) 228-6115
4015 Executive Park Drive Cincinnati, Ohio 45241 Phone (513) 563-4220
1900 Euclid Avenue Cleveland, Ohio 44115 Phone (216) 771-4747
3450 West Central Avenue Toledo, Ohio 43606 Phone (419) 535-0616

PICO'S FAMILY AUTO AND HOMEOWNERS INSURANCE ISN'T FOR EVERYONE

PICO's family auto and homeowners insurance policies feature competitive rates, comprehensive coverages and are backed by the company's always professional claims and policyholder services.

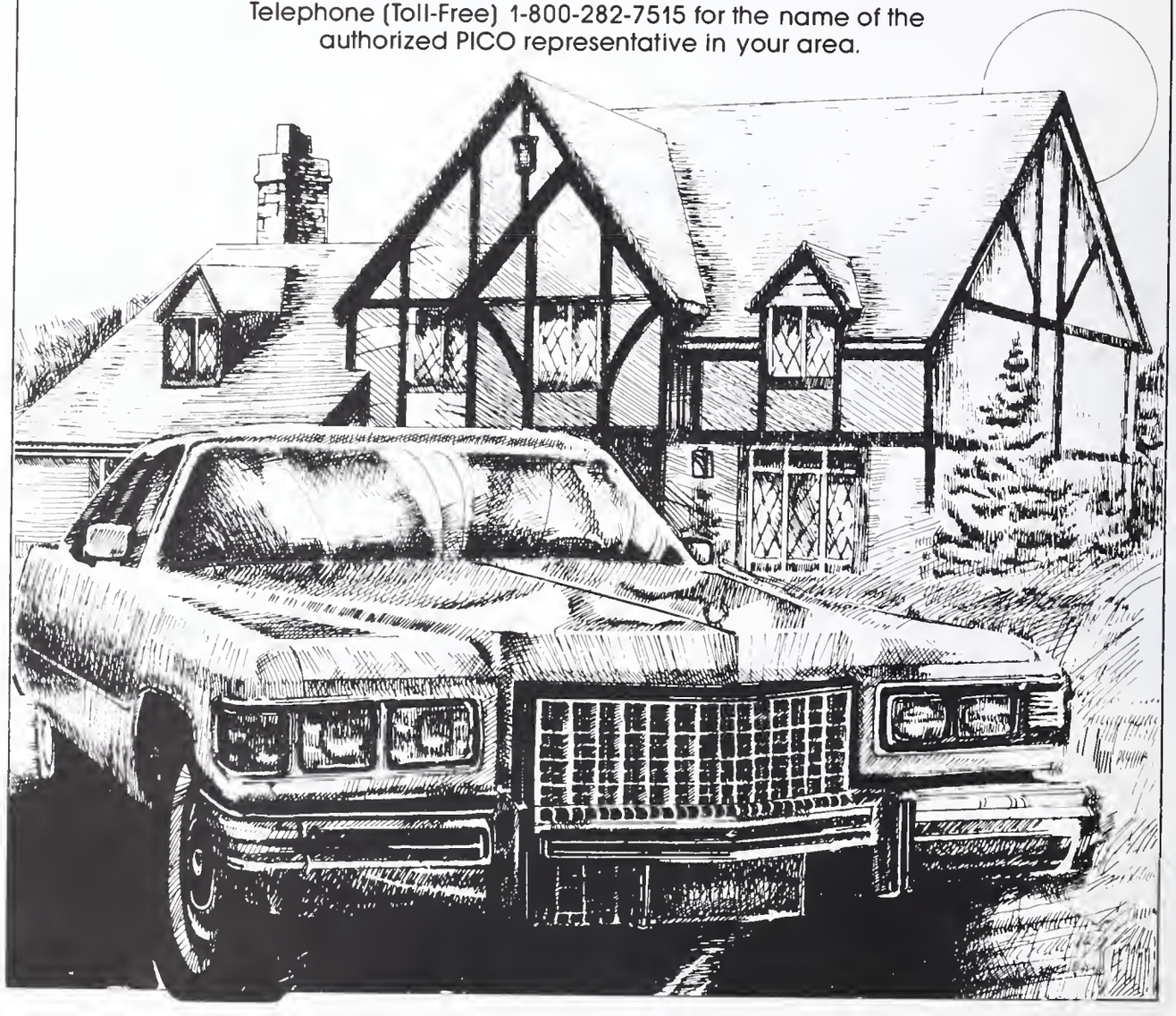
They're not for everyone, however. They were developed by an Ohio insurance company formed specifically to serve physicians and are offered only to members of the O.S.M.A.

That makes PICO family auto and homeowners insurance rather special.

PICO

Physicians Insurance Company of Ohio
P.O. Box 27905
6100 Channingway Boulevard
Columbus, Ohio 43227

Telephone (Toll-Free) 1-800-282-7515 for the name of the authorized PICO representative in your area.



History of Homeopathic Medicine at Oberlin, Ohio 1833---1933

A. Clair Siddall, M.D.

IN THE 19TH CENTURY, orthodox medicine in this country was faced with an increasing number of heretical competitors. This was especially true in the State of Ohio, where the rapid growth of the population created a shortage of regular physicians. From 1800 to 1850, the population of Ohio swelled from 42,000 to two million. This period also saw a consumer rebellion against the traditional medical profession because of the practice of bloodletting and the use of calomel for the treatment of almost every disease.[1] One Oberlin College professor observed: "while ignorance, self-conceit, and brazen-faced audacity characterize so many physicians, general distrust must be expected."[2]

As late as 1853, Oberlin College students were still debating the subject: "medical practice has been a curse to the world."[3] This hostile mood became so pervasive that the Ohio State Legislature bowed to popular pressure and, in 1833, repealed all statutes which regulated medical practice in any way.[4] (Such drastic action took place in all states except two.[5]) At that time, Ohio became known as a haven for irregular practitioners and quacks. The result was a wave of popularity which greeted Grahamism, thomsonianism, hydropathy, phrenology, mesmerism, faith healing, orthopathy,[6] and, finally, homeopathy.

The author intends to present a brief reference to the growth of homeopathic medicine across the United States and to dwell more specifically on the rise and decline of this group of practitioners in the City of Oberlin, Ohio. He will also discuss the favorable influence that homeopathy exerted on the entry of women into the practice of medicine.

Although homeopathic physicians studied anatomy and physiology, as did the orthodox profession, they differed in their theory and practice of therapeutics. Their unproven claim was that each drug increased in effectiveness in direct relation to its increased dilution.[7] With justification, they rejected the idea of the established physicians that "the only way to get health into a man was to let the blood out of him."[8] The followers of conventional medicine heaped ridicule and constant opposition on practitioners of homeopathy, and they refused to meet them in consultation.[9]

Nevertheless, homeopathic medicine enjoyed wide popularity after 1841. This was due in part to many botanic practitioners (thomsonians) joining their ranks.[10] Also, many orthodox physicians gradually embraced homeopathy.[11]

By 1900, the homeopathic sect reached its highest point: supporting 22 medical colleges, maintaining national and regional societies, and publishing journals.[12] There was an estimated one homeopath for every ten allopaths in the United States.[13] In the State of Ohio in 1893, there were 1,000 homeopaths[14] and 4,036 allopaths.[15] Included in the homeopath count were nine women, one practicing in Oberlin. At the turn of the century, one homeopathic physician voiced the pride of his colleagues when he said: "homeopathy, founded as it is, on immutable, unchanging law, is destined to triumph throughout the world."[16]

It is not surprising that Oberlin's chief antagonist to homeopathy was Dr. James Dascomb, who embodied the attributes of orthodox medicine.[17] He had joined the Oberlin Colony in 1834, one year after its founding, bringing excellent qualifications as a recent graduate of Dartmouth Medical School. After practicing for two years, he confined his time to teaching science in the Oberlin Collegiate Institute; but he never lost his interest in the medical profession.

His common-sense attitude concerning matters of health proved to be a stabilizing influence on the entire community. The sporadic enthusiasm of the college students for phrenology, mesmerism, spiritualism, and orthopathy were quickly moderated after seeking Dr. Dascomb's opinion.[18] Early in his career, he successfully opposed the extreme views of Grahamism and orthopathy at a time when those ideas were in favor with the local college leaders. Dr. Dascomb stood as the caretaker for sound scientific medicine.

As Dr. Dascomb watched the steady growth of homeopathy in the United States and in Ohio, he was determined to set the record straight for the protection of the local residents. In 1850, this led him to present an address entitled "Principles and Practice of Homeopathy" before The Oberlin Society of Inquiry.[19] He reviewed the tenets of the founder of homeopathy, Samuel Hahnemann,[20] and dwelled upon the new theory of therapeutics that "likes are cured by likes" *(similia similibus curantur)*. Hahnemann's experimental approach was to give a large dose of one particular drug to a well person. If the disturbing

---

Dr. Siddall, Oberlin, retired in 1972 from the Department of Obstetrics and Gynecology, Oberlin Clinic, Oberlin, Ohio.

A list of references may be obtained from Dr. Siddall at 345 Edgemeer Place, Oberlin, Ohio 44074.

Presented at the Annual Meeting of the Ohio Academy of Medical History on May 7, 1977 in Columbus, Ohio.

Submitted June 28, 1977.

symptoms produced simulated the actual symptoms of a known disease, he declared that that drug would be a specific treatment for that ailment. Hahnemann also arrived at the strange conclusion that drugs in their crude state were inert, but when triturated with mortar and pestle, they became spiritualized or dynamized so as to become more powerful. In addition, he believed that the potency of a drug was increased when taken at exceedingly high dilutions.

Dascomb declared bluntly that such theories contradicted all of man's knowledge and common sense. Dascomb responded to the homeopathic claim that the final test is that the patients recover under their system by saying many of those patients would recover if simply left alone. Following this close analysis of homeopathy, Dascomb challenged any homeopath to submit any medication for a double-blind study. It was obvious to Dascomb that this irregular sect was more interested in perpetuating its errors than in searching for proof of its concepts.

If Dascomb entertained any hope that his public discussion might discourage the homeopath from settling in Oberlin, he was to be disappointed. About one year after Dascomb's lecture, Dr. David Keys set up a homeopathic practice in Oberlin, but he stayed only two years.[21] His reception by the local physicians was, no doubt, less than lukewarm. Almost five years were to pass before the second homeopath arrived in Oberlin in 1858. Dr. M. P. Hayward located his office at 8 East College Street.[22] He must have created friction with the established physicians when he wrote a letter to the local newspaper editor in which he criticized the physicians for treating appendicitis by operation.[23]

In turn, the homeopaths were criticized for advertising. Dr. J. N. Wheat, who practiced homeopathy in Oberlin, announced in the local press that he would remove cancers without the knife.[24] Dr. MacFarland's homeopathic advertisement occupied half the front page of the *Oberlin News* in 1888. It extolled the merits of his great medicinal discovery: a mixture useful in all diseases.[25] He moved away the following year.

The vast majority of homeopathic physicians who practiced in Oberlin came during the latter half of the 19th century. Many stayed only a short time, which indicates their lack of any deep impact on the community. In the year 1896, when Oberlin had less than 5,000 citizens, it was overpopulated with doctors. There were four homeopaths, one eclectic, and eight orthodox physicians.[26]

Although the available records are incomplete, it is likely that only four of the local homeopaths could boast of a college degree. All of these were graduates of Oberlin College (Dr. Clarinda Parmalee Chapman, 1850,[27] Dr. Julia Chapin Jump, 1864,[28] Dr. E. H. Jewett, 1878,[29] and Dr. Franklin Freeman, 1884.[30])

The career of Dr. Freeman reveals the common pattern for physicians to change locations frequently. After securing his MD degree from the Chicago Homeopathic Medical College in 1889, he practiced in Redwood City, California, for three years. Then he stayed in Oberlin for only one year, but there is no way to know if his arrest for intoxication hastened his departure.[31] His next move was to Oregon, Illinois, where he worked for 11 years, following which he practiced one year in Chelsea, Georgia. His final location was in Chattanooga, Tennessee.

Dr. Samuel Ackelson, homeopath, who arrived in the 1870s, survived four years. He had made a sizable investment in a sanatorium for the treatment of chronic diseases. This facility was located at the corner of North Main and Lorain Streets. Like many other practitioners of this sect, he offered electric, vapor, and sulphur baths.[32]

The two outstanding and more successful homeopathic physicians in Oberlin were women: Dr. Julia Jump, who served the community for 13 years, and Dr. Ellen Spaulding Hawkins, whose tenure reached 35 years.[33] Such favorable acceptance by the local citizens must have resulted from the fact that each of them had been acquainted with Oberlin residents prior to their study of medicine. Even if the hostility of the orthodox physicians toward homeopaths had diminished toward these two women, there is indirect evidence that prejudice and aloofness remained. No mention can be found in private or public records that indicates that these female practictioners ever were included in the conferences dealing with community health problems or hospital planning with the local regular physicians.[34]

Dr. Jump did not graduate from Oberlin College until she was 33 years old. She was born in Oneida County, New York in 1832.[35] Four years later, her family moved to Brownhelm, Ohio and from there to North Amherst, Ohio, where she attended the common schools. When she started teaching school at the age of 17 years, her salary was $1 a week, and she "boarded round." Six years after her marriage in 1852, a move to Oberlin opened the way for her to enter Oberlin College, where she taught in the Academy for three years. Her college degree then merited a teaching position in the Oberlin grammar schools for nearly five years followed by 12 years in the Cleveland public schools.

While in Cleveland, she decided to fulfill her ambition to enter the field of medicine. At the age of 52 years, she graduated from the Cleveland Homeopathic Hospital Medical College, in 1884. That same year, she returned to Oberlin to set up solo practice where she was well known and had many friends. Later on, it was a sign of unusual success when she began to attract a number of male patients in addition to the many women and children.[36] Dr. Jump became an active member in the county, state, and national homeopathic medical societies. In 1891, she was honored by being accepted as a Fellow of the Hahnemann Society.[37] For her competence, she received an appointment as a member of the Board of Censors at the Cleveland Homeopathic Hospital Medical College. Her busy practice was terminated by her unexpected death March 15, 1897, at the age of 65 years.[38]

The second more successful woman physician to practice in Oberlin was Ellen Hawkins. In 1892, ten years after the death of her husband, she came to Oberlin and lived with her two sisters for one year. She found a congenial atmosphere and in 1897, she returned to start her medical practice. She had received her doctor of medicine

degree that same year from the Cleveland Homeopathic Hospital Medical College. She was 52 years old. Her quiet, confident manner helped her to maintain a reasonably large clientel of women and children patients for many years. She never retired. Even during her closing years, when she became thin and slightly stooped, she continued her daily walk downtown, always carrying her small, elongated, black leather, medical bag. She was able to climb the long stairs to her office at 33 West College Street until one week before her death at the age of 86 years.[39]

A search of the available records reveals that there were 18 authenticated homeopathic physicians located in Oberlin during the years 1833 to 1933. Their names and decade of arrival are shown in Table 1.[40]

Table 1. Homeopathic Physicians in Oberlin, Ohio 1833 — 1933

Name	Decade
David C. Keys	1850s
M. P. Hayward	
Mrs. E. H. Barry	1860s
J. N. Wheat	
Mrs. Clarinda Chapman	
J. E. Lowes	
Samuel Ackelson	1870s
G. T. Jones	
E. H. Jewett	
John Austin	1880s
Mrs. Julia Jump	
D. H. Patchen	
C. H. MacFarland	
D. G. Wilder	1890s
Mrs. Ellen Hawkins	
Harold W. Pyle	
Franklin C. Freeman	
F. O. Eggleston	1900s

Six more women appeared in the register then.[41] Although there is no special designation noted, they likely were practitioners of homeopathy because the vast majority of women at that time found only homeopathic and eclectic schools of medicine open to them. Adding these names to the list in Table 1 would bring the total number of homeopaths in Oberlin during that hundred years to 24, ten of whom were women. The homeopathic and eclectic colleges even eagerly sought women students while the doors of orthodox schools were closed to them.[42] During the 19th century, most men — and probably the majority of women — viewed feminism with abhorence, and the thought of "female doctors" was absurd.[43]

This attitude toward women physicians was further evidenced when the first school for women physicians[44] sought to merge with the orthodox medical college of Harvard University in 1874. They met a flat refusal,[45] however, the homeopathic Boston University College of Medicine took them in.[46] In Cleveland, the total number of women graduated from homeopathic schools from 1852 to 1914 was about 260. In contrast, only approximately 64 women were graduated by the traditional medical colleges in Cleveland before 1915.[47] During the years between 1833 and 1933, Oberlin had only one practicing woman physician who had a doctor of medicine degree from a regular medical college.[48] Although the first woman in the United States received her degree from an orthodox medical college in 1849, it was 66 years before such women graduates were admitted to membership in the American Medical Association.[49,50]

This prejudice against women in medicine did not diminish until more recent times. In 1859, Dr. Charles D. Meigs, Philadelphia's most prominent gynecologist, reflected the general opinion of the 19th century when he wrote that the place for woman was in the home, "except when, like the star of day, she deigns to issue forth to the world, to exhibit her beauty and grace."[51] Until 1850, from a legal viewpoint, women were considered perpetual minors. In almost every state, wife beating "with a reasonable instrument" was lawful.[52] Prior to the 20th century, men in medical practice exhibited a double prejudice against women entering the profession, first because of their sex and the second if they were educated in homeopathy.

It is this opposition to women entering the learned professions, except teaching, that offers a clue as to why so many women physicians gravitated to the small village of Oberlin. By tradition, certain woman's rights were favored in Oberlin.[53] Oberlin College was the first institution in the United States to admit women on an equal basis with men,[54] and as early as 1853, Oberlin College gave to America its first ordained woman as a Protestant minister.[55] In the 1850s, Oberlin College women also showed a real interest in the medical field. One of their literary societies held a debate on the subject, "Resolved that women should enter the medical profession."[56] The speakers for the affirmative side won the decision. This interest was translated into reality before the end of the century, when 26 Oberlin College female graduates succeeded in obtaining the degree of doctor of medicine. For comparison, the figures in Table 2 include both male and female graduates from Oberlin College and indicate those from orthodox or unorthodox schools.[57]

Table 2. Oberlin College Graduates Receiving M.D. Degrees in 19th Century (Including 1900)

	Homeopathic	Eclectic	Orthodox	Total
Female	7	2	17	26
Male	7	0	71	78
Total	14	2	88	104

While over 50 percent of the women physicians finished their medical education in irregular schools, only 10 percent of the men did so. It is remarkable that 25 percent of all Oberlin College graduates in this period who continued on into medicine were women.

As expected, the majority of all physicians in Oberlin during the 100 years from 1833 to 1933 were graduates of orthodox colleges of medicine. A comparison with the

number of unorthodox practitioners is presented in Table 3.[58]

The question naturally arises that if homeopathy was founded on false premises, why did it carry such wide appeal for over three-quarters of a century. It is obvious that many physicians and laymen accepted its tenets as valid since its therapeutics seemed to be based on scientific experimentation. Also, many parents found the small, sweet, homeopathic pills and diluted solutions to be acceptable to children as well as adults, and a preferable choice over the bloodletting and the use of calomel of the regular physicians. Furthermore, the public was favorably impressed by the statistics published in 1855 indicating that the homeopathic cure rate for cholera was much better than that of the regular physicians.[59] Many people also approved of the homeopathic physicians encouraging them to save money by purchasing a family kit filled with vials of pills accompanied by directions for self-medication.[60]

Although the practice of homeopathy showed many signs of success across the country toward the close of the 19th century, there were changes taking place that were undermining its vitality. As early as 1880, many homeopathic physicians began to doubt the validity of their therapeutic theory and did not hesitate to dispense allopathic medicines along with their own.[61] Many also wanted to associate with traditional practitioners and gain the benefit of their consultations. As the orthodox schools of medicine greatly improved and new discoveries were made, especially in bacteriology, the homeopathic colleges lagged behind and lost prestige. The leaders of the established profession took notice of these changes and, in 1903, they invited their irregular colleagues to join the American Medical Association as full members.[62]

The result was that one homeopathic school after another was forced to close. The Cleveland-Pulte Homeopathic College, where many women had been trained, finally terminated operation in 1914. In 1922, the homeopathic division of The Ohio State University closed its doors.[63] Hahnemann's theory and practice in Ohio were almost extinct. In Oberlin, homeopathy did not pass from the scene until the death of Dr. Ellen Hawkins in 1932.

Dascomb's dissertation against homeopathy was well taken in 1850. Yet today in retrospect, homeopathy merits a more favorable consideration for its ultimate influence upon the field of medicine. First, along with others, it forced the conventional practitioners to give up the harmful and obsolete practice of bloodletting and the use of calomel. Second, it proved to be the stimulus which led orthodox medicine to improve medical education.

TABLE 3. Practitioners of Medicine in Oberlin, Ohio 1833 — 1933

Type of Physician		No.
Orthodox		
In residence		59
Traveling (one day a week or one day a month)		6
Unorthodox		
In residence		38
Orthopathic	1	
Botanic	1	
Homeopathic (6 not verified)	25	
Eclectic	2	
Osteopathic	6	
Chiropractic	2	
Magnetic Healing	1	
Traveling (one day a week)		1

Acknowledgement: The author acknowledges the assistance and encouragement of William Bigglestone, Archivist of Oberlin College, Oberlin, Ohio.



WINDSOR HOSPITAL
A NONPROFIT CORPORATION
— ESTABLISHED 1898 —
Chagrin Falls, Ohio
247 - 5300
A hospital for the treatment of Psychiatric Disorders
High on a Hill-Top, Overlooking Beautiful Chagrin River Valley.
Accredited by Joint Commission on Accreditation of Hospitals.
Booklet available on request.
FRIEDRICH A. LINGL, M.D. Medical Director
GUY H. WILLIAMS, JR., M.D. Medical Director Emeritus
HERBERT A. SIHLER Jr. President
MEMBER: American Hospital Association—National Association of Private Psychiatric Hospitals



Simple drops of water help make COLACE® the most widely used stool softener.

COLACE®
dioctyl sodium sulfosuccinate

COLACE works by stool-softening action alone, free from laxative stimulation. Simply by letting natural intestinal water permeate stools, COLACE helps to eliminate the hard, dry stools common to constipation.

COLACE works to prevent pain and straining at stool with minimum chance of griping or cramps, particularly in patients with delicate anorectal disorders. COLACE is safe and non-habit forming in short- or long-term therapy. COLACE—the simple water way to ease constipation from infancy to old age. Capsules, syrup or liquid.

© Mead Johnson & Company-Evansville, Indiana 47721 U.S.A.

Mead Johnson PHARMACEUTICAL DIVISION

11373

COMPATIBILITY



Eastern Tiger Swallowtail Butterfly
(Papilio glaucus)

Does it influence your choice of a peripheral/cerebral vasodilator*?

Vasodilan–compatible with coexisting diseases (e.g., glaucoma, diabetes)

Vasodilan has not been reported to affect the course of coexisting disease; it has not been reported to affect blood sugar levels or to raise intraocular pressure.

Vasodilan–compatible with concomitant therapy

Vasodilan has not been reported to affect the treatment of coexisting disease; it is compatible with such drugs as hypoglycemics and miotics.

Vasodilan–compatible with your total regimen for vascular insufficiency

Vasodilan can be a valuable adjunct in planning a total therapeutic program for vascular insufficiency.

*Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:
Possibly Effective:
1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.
Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.
Dosage and Administration: Oral: 10 to 20 mg., three or four times daily.
Intramuscular: 5 to 10 mg.(1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.
Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.
Parenteral administration is not recommended in the presence of hypotension or tachycardia.
Intravenous administration should not be given because of increased likelihood of side effects.
Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.
Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.
Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.
Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

U.S. Pat. No. 3,056,836



VASODILAN® 20-mg tablets
(ISOXSUPRINE HCl)
20 mg q.i.d. recommended dosage

Mead Johnson
PHARMACEUTICAL DIVISION

© 1978 MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA 47721 U.S.A. MJL 7 4237R

This asthmatic isn't worried about his next breath...



he's active he's effectively maintained on

QUIBRON®

Each capsule or tablespoon (15 ml) elixir contains theophylline (anhydrous) 150 mg and glyceryl guaiacolate (guaifenesin) 90 mg. Elixir: alcohol 15%

- high theophylline for effective around-the-clock therapy
- 100% free theophylline
- individualized theophylline dosage schedule

Indications: For the symptomatic treatment of bronchospastic conditions such as bronchial asthma, asthmatic bronchitis, chronic bronchitis, and pulmonary emphysema.

Dosage: Initial: Adults: 1-2 capsules or 1-2 tablespoonfuls elixir every 6-8 hours, children 8-12: 1 tablespoonful or one capsule every 6-8 hours and children under 8: 3 to 5 mg theophylline/kg body weight every 6-8 hours. Theophylline dosage may be cautiously increased to 2000 mg/24 hr in adults or 7 mg/kg in children; monitoring of serum theophylline levels at higher dosages is recommended.

Precautions: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other xanthine derivatives concurrently. Use in case of pregnancy only when clearly needed.

Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea and vomiting. The frequency of adverse reactions is related to the serum theophylline level and are not usually a problem at serum theophylline levels below 20μg/ml.

How Supplied: Capsules in bottles of 100 and 1000 and unit-dose packs of 100; Elixir in bottles of 1 pint and 1 gallon.

Mead Johnson

PHARMACEUTICAL DIVISION

© 1978 Mead Johnson & Company • Evansville, Indiana 47721 U.S.A. MJL 6-4220R

THE OHIO STATE Medical Association

Obituaries

HENRY A. CRAWFORD, M.D., Cleveland; Western Reserve University School of Medicine, 1927; age 74; died December 15, 1977; member OSMA and AMA.

At the time of his death, Dr. Crawford was President of the Ohio State Medical Board, having served continuously since 1967. He held the presidency previously in 1971-1972. In addition, Dr. Crawford was Past President of the Ohio State Medical Association (1965) and had just completed his term as a Delegate to the American Medical Association, a position he had held since 1967. A proctologist and colon/rectal surgeon, Dr. Crawford was a Fellow of the American Association of Colon and Rectal Surgeons and a Diplomate of the American Board of Surgery. He was a Past President of the Academy of Medicine of Cleveland, whose membership elected him to Distinguished Membership in the Academy. Dr. Crawford served on active duty as Combat Observer and Flight Surgeon in the United States Air Force (1940-1946) and was awarded the Air Medal and the Bronze Star. He retired with the rank of colonel after 36 years of service in the Air National Guard. Dr. Crawford is pictured below at the December 1977 AMA Interim Meeting. He is to the right of Ohio Delegates H. William Porterfield, M.D., and W. J. Lewis, M.D.



WALTER S. CURTIS, M.D., Menands, New York; Harvard Medical School, Boston, 1925; age 87; died November 24, 1977; member OSMA and AMA.

CARR E. DIX, M.D., Columbus; Western Reserve University School of Medicine, 1938; age 64; died December 1, 1977; member OSMA and AMA.

SAMUEL C. ELLIS, M.D., Xenia; Ohio State University College of Medicine, 1935; age 70; died November 27, 1977; member OSMA and AMA.

WILLIAM L. FAUL, M.D., Georgetown; Eclectic Medical College, Cincinnati, 1928; age 76; died November 17, 1977; member OSMA and AMA.

HARRY E. FUSSELMAN, M.D., Avon Lake; Western Reserve University School of Medicine, 1920; age 83; died November 8, 1977; member OSMA and AMA.

JACK I. GILFORD, M.D., Hallendale, Florida; Ohio State University College of Medicine, 1932; age 71; died November 25, 1977; member OSMA and AMA.

ARNOLD V. GOLD, M.D., Akron; University of Louisville School of Medicine, 1939; age 65; died December 4, 1977; member OSMA and AMA.

C. ROWELL HOFFMAN, M.D., Covington, Kentucky; University of Cincinnati College of Medicine, 1941; age 62; died December 1, 1977.

RAY C. JANOVSKY, M.D., Cleveland; Western Reserve University School of Medicine, 1946; age 55; died November 19, 1977; member OSMA and AMA.

MYRON KISHMAN, M.D., Elyria; Western Reserve University School of Medicine, 1923; age 81; died November 21, 1977; member OSMA and AMA.

DANIEL KORNBLUM, M.D., Toledo; State University of New York College of Medicine, 1930; age 69; died December 2, 1977; member OSMA and AMA.

EDWIN J. LLOYD, M.D., Baltimore; Temple University School of Medicine, Philadelphia, 1941; age 64; died December 2, 1977; member OSMA and AMA.

KEITH R. MILES, M.D., Stuart, Florida; Ohio State University College of Medicine, 1939; age 64; died November 14, 1977; member OSMA and AMA.

IRVILLE S. RIAN, M.D., Newark; Ohio State University College of Medicine, 1929; age 76; died November 17, 1977; member OSMA and AMA.

NORMAN ROSENBERG, M.D., Cleveland; Georgetown University School of Medicine, Washington, D.C., 1942; age 60; died November 19, 1977; member OSMA and AMA.

EDWARD SCHUMACHER, M.D., Cleveland; University of Illinois School of Medicine, 1940; age 65; died December 7, 1977; member OSMA.

LOUIS R. SNYDER, M.D., Cincinnati; University of Cincinnati College of Medicine, 1934; age 69; died November 22, 1977; member OSMA and AMA.

MYRON E. SPECK, M.D., Cleveland; Ohio State University College of Medicine, 1931; age 78; died November 22, 1977; member OSMA and AMA.

When impotence due to androgenic deficiency is driving them apart



Android®-5 Buccal Tabs
Android®-10 Oral Tabs
Android®-25 Oral Tabs

Methyltestosterone U.S.P. – 5, 10, 25 mg.

Additional Indications:
REPLACEMENT THERAPY. When Androgen Deficiency is cause of:

- Male Climacteric
- Eunuchoidism, Eunuchism
- Post-Puberal Cryptorchidism

New Double-Blind Study ANDROID-25 vs. Placebo*

*R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.; Hormones for Improved Sexuality in the Male and Female Climacteric. **Drug Therapy,** Sept. 1976.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE: Robert B. Greenblatt, M.D.,** and **D. H. Perez, M.D.:** "The Menopausal Syndrome," *Problems of Libido in the Elderly,* pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

BROWN **THE BROWN PHARMACEUTICAL CO., INC.** 2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

The Ohio State Medical Association Colleagues in the News

RICHARD H. BURK, M.D., and **JOHN W. WALTHER, M.D.,** Assistant Clinical Professor of Medicine and Assistant Clinical Professor of Family Practice. respectively, at Wright State University School of Medicine, have been appointed Co-directors of Medical Education and Development at Stouder Memorial Hospital.

The Cleveland Clinic has a former Columbus journalist as its new director of public relations. **MRS. JAYNE ELLISON,** who first moved to Cleveland in 1974 as the medical writer for *The Plain Dealer*, took over the position in December 1977. Previous to this position and her stint with *The Plain Dealer,* Mrs. Ellison was a medical reporter for the *Palm Beach Post* (Florida), the *Dayton Daily News,* and the *Columbus Citizen Journal.* Also, she had directed the news service for four years at The Ohio State University Medical Center, including the Colleges of Medicine and Dentistry and the School of Nursing.

FRANK FALKNER, M.D., Fels Professor in Pediatrics at Wright State University School of Medicine, has been elected to membership in the Societe Francaise de Pediatrics.

NICHOLAS J. GIANNESTRAS, M.D., Cincinnati, recently served as Visiting Professor to the Department of Orthopedics of the University of the Philippines and to the Philippines General Hospital, Manila. Dr. Giannestras discussed scoliosis and problems of the foot in the adolescent.

JOHN G. GUJU, M.D., Youngstown, has been elected president of The Youngstown Society of Obstetricians and Gynecologists. Other officers elected for the 1977-1978 term are **SIMON W. CHIASSON, M.D.,** vice-president/president-elect; **VINCENT D. LEPORE, M.D.,** secretary-treasurer; **HOWARD X. KRAMER, M.D.,** chairman of the Educational Committee.

KENNETH HASHIMOTO, M.D., has been appointed Professor of Medicine and Anatomy and Director of the Group in Dermatology in the Department of Medicine of Wright State University School of Medicine. Previously, Dr. Hashimoto was Professor of Medicine and Associate Professor of Anatomy at the University of Tennessee Center for the Health Sciences, and Chief, Section of Dermatology, Medical Investigator, and Director of the Electron Microscopy Laboratories at the Memphis Veterans Administration Hospital. Dr. Hashimoto is a member of the Society for Investigative Dermatology and the American Academy of Dermatology.

SHERMAN E. KAHN, M.D., Assistant Clinical Professor of Community Medicine at Wright State University School of Medicine, has been made a Fellow of the American College of International Physicians.

PETER A. LANCIONE, M.D., Bellaire, has been elected President of the Ohio State Medical Board. Also elected were **HENRY G. CRAMBLETT, M.D.,** Columbus, Vice-President; and **ANTHONY J. RUPPERSBERG, JR., M.D.,** Columbus, Secretary-Treasurer.

MAURICE F. LIEBER, M.D., formerly of Canton and now residing in Florida, was recently awarded a certificate for outstanding service to Aultman Hospital and the community. Dr. Lieber, who practiced in Canton for 30 years, is a past president of the OSMA. At the ceremony, **WILLARD J. HOWLAND, M.D.,** Director of Radiology at Aultman Hospital since 1968, was installed as president of the hospital medical staff.

H. WILLIAM PORTERFIELD, M.D., Columbus, has been elected Treasurer of the American Society of Plastic and Reconstructive Surgeons. Also a member of the American Society for Aesthetic Plastic Surgery, Inc., he is certified by the American Board of Plastic Surgery. Dr. Porterfield is a member of the Ohio Delegation to the AMA and is Chairman of the Ohio Medical Political Action Committee (OMPAC).

H. JUDSON REAMY, M.D., Dover, has been named Chairman of the Continuing Education Committee of the American Academy of Family Physicians. Dr. Reamy is Past President of the Ohio Academy of Family Physicians.

RONALD WITTEL, M.D., Canton, has been elected to membership in the American Roentgen Ray Society. A pediatric radiologist, Dr. Wittel is also a member of the Society of Pediatric Radiology.

"Colleagues in the News" is sponsored by

Blue Shield
Ohio Medical Indemnity, Inc.

6740 North High Street, Worthington, Ohio 43085

(614) 438-3500
(PAID ADVERTISEMENT)



1978 Annual Meeting, Ohio State Medical Association

DO YOU HAVE AN EXHIBIT or know of an exhibit which is of scientific interest? If you do, the Ohio State Medical Association Annual Meeting is just the place to display it. We are now accepting applications for the 1978 OSMA Annual Meeting. Those eligible to apply are as follows: (1) Exhibits by Ohio physicians, Ohio medical schools, hospitals or similar organizations; (2) Out-of-state physicians or out-of-state agencies on invitation; (3) Voluntary health organizations.

Exhibits will be set up and viewed at the Dayton Convention and Exposition Center, 22 Dave Hall Plaza, Dayton, Ohio. Exhibit Days and Times will be as follows: Monday, May 8 — 12 NOON - 4:30 PM; Tuesday, May 9 — 9 AM - 4:30 PM; and Wednesday, May 10 — 9 AM - 12 NOON.

Mail applications to the attention of Vincent T. La Maida, M.D., Chairman, Subcommittee on Scientific Exhibits, Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215.

APPLICATION FOR SPACE
SCIENTIFIC EXHIBITS

1978 Annual Meeting, Ohio State Medical Association

Dayton Convention and Exposition Center, Dayton, May 8, 9, and 10

___I am interested in receiving an application and details regarding space for a scientific exhibit at the 1978 OSMA Annual Meeting. Please send to:

Name_____

Address_____

City_____ State_____ Zip_____

THE OHIO STATE Medical Association

Letters to the Editor

To the Editor:

I want you to know I think the current November issue* of *The Ohio State Medical Journal* is magnificent. Of course, I realize I am a little prejudiced but I think it is so well done and timely that it may be read by a lot of our membership and hopefully not tossed aside with the mound of material that accumulates on every doctor's desk every day.

Yours Sincerely,
s/Physician Member
International Doctors in
Alcoholics Anonymous

* * * *

To the Editor:

I was impressed by the November issue* of your *The Ohio State Medical Journal* series of articles about the Ohio State Medical Association Physician's Effectiveness Program.

I would like very much to have 13 copies of the November issue of your *Journal* for distribution to our Committee on Physician's Health and Effectiveness.

Sincerely,
s/William N. Hilliard
Executive Director
North Carolina Medical Society

* * * *

To the Editor:

This* looks like a very good issue of your *Journal* and I am passing it along to one of the section chiefs in our adult hospital who has been involved in our Alcoholism Recovery Program.

Sincerely
s/Don Richards
Director of Information
The Menninger Foundation

---

*Volume 73, Number 11, November 1977.

IMMKE CIRCLE LEASING INC

Endorsed Leasing Company
Of The Ohio State Medical Association

Immediate delivery on many 1978 models

We lease all foreign and domestic makes and models including Mercedes, Jaguar, Porsche, etc.

Immke Circle Leasing, Inc.
32 South Fifth Street
Columbus, Ohio 43215

Telephone 614-228-1701 or
Toll Free 1-800-282-0256

BURROUGHS WELLCOME CO. MAKES CODEINE COMBINATION PRODUCTS.

YOU MAKE THE CHOICE.



EMPIRIN® COMPOUND c̄ CODEINE #3

Each tablet contains:
codeine phosphate, 32 mg (gr ½),
(Warning: May be habit-forming);
aspirin, 227 mg; phenacetin, 162 mg;
and caffeine, 32 mg.

EMPRACET™ c̄ CODEINE #3

Each tablet contains:
codeine phosphate, 30 mg (gr ½),
(Warning: May be habit-forming);
and acetaminophen 300 mg.

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Classified Ads

Rates: $3 per line. Display classified: $5 per line. Minimum 3 lines per insertion. Ads measure 8 lines to the inch. Box number reply: Flat $5 charge in addition to line cost for up to and including three insertions. (Covers cost of mailing replies which are kept confidential.) Forms close the 10th day of the month preceding month of publication. Address all ads Attention: Classified Ad Department, ***The Journal.***

To assure prompt delivery, when replying to an advertisement over a ***Journal*** box number, address letters as follows: Box (insert number), c/o ***The Ohio State Medical Journal,*** 600 South High Street, Columbus, Ohio 43215.

GENERAL PRACTITIONER WANTED: To join multispecialty group practice in Northeastern Ohio. Present group consists of two surgeons, two internists, and two general practitioners. General practice limited primarily to adult medicine. No surgery or obstetrics required. For further information call collect or write: Glenn E. Eippert, M.D., or Richard S. Millberg, M.D., 430 West 25th St., Ashtabula, Ohio 44004. Phone: 216/998-1212.

FAMILY PRACTICE: Long-established general practice in Southwest Ohio. Urban practice with five open-staffed hospitals and medical college. Practice and office can accommodate one or two family practitioners. Present practitioner leaving but will stay as long as necessary to introduce. Contact Box 821 c/o Ohio State Medical Journal.

OBSTETRICIAN-GYNECOLOGIST WANTED: To join well-established corporation in Central-Northwestern Ohio city. First-year salary $40,000; with benefits $74,000. Early full membership in corporation. Partner of 25 years retiring. Contact Box 820 c/o Ohio State Medical Journal.

HOUSE PHYSICIANS WANTED: For a community hospital located in northeast Ohio. Housing and uniform allowances provided. Attractive fringe benefits, including insurance. Salary negotiable. Must have current Ohio licensure. Reply Box 813 c/o Ohio State Medical Journal.

PSYCHIATRIST: For community mental health center using case-manager model. Begin $41,600. Board eligible. 32 hours per week. Private practice allowable. Liberal fringes. Moving expenses. Open October 1, 1977. Resume/three reference letters to Personnel, Scioto Paint Valley Mental Health Center, 50 Pohlman Road, Chillicothe, Ohio 45601, telephone 614/775-1260.
EQUAL OPPORTUNITY EMPLOYER

MENTOR, OHIO: New office building. $10/sq. ft. includes all improvements to your design with option to buy building. Inquiries to: G. Guttmann, 26300 Euclid Avenue, Euclid, Ohio 44132.

GENERAL SURGICAL RESIDENCY: Fully-approved, five-year residency at Cleveland's Lutheran Medical Center offers two positions at PGY2 level, beginning July 1978. Candidates must be graduates of American or Canadian schools of medicine. Contact: Joseph C. Avellone, M.D., Director of Surgery, Lutheran Medical Center, 2609 Franklin Boulevard, Cleveland, Ohio 44113.

MARION, OHIO: Excellent opportunities in Central Ohio. Existing and new, solo, partnerships, or association practices available and seeking physician support. Top compensation— reliable cross coverage. Exceptionally attractive, 250-bed, well-equipped regional medical center hospital within walking distance from offices. Industry and agriculture support city/45,000; county/65,000; and total trade area/250,000. Excellent schools and residential areas. Fifty-minute, easy drive to Columbus. Active need for—

OB/GYN
FAMILY PRACTICE
INTERNAL MEDICINE
OTOLARYNGOLOGY
PEDIATRICS
ORTHOPEDIC SURGERY
EMERGENCY MEDICINE
ANESTHESIOLOGY
GENERAL SURGERY

We are seeking either rural or city-oriented physicians. Send C.V. or contact— ROBERT FLINT, Marion General Hospital, MARION, OHIO 43302 — or call 614/382-8211 or 382-3442 any time.

GENERAL PHYSICIANS: Needed for full-time, salaried positions in student health care facility. Predictable daytime hours. Liberal vacations and long weekends at desirable times. Ohio licensure and enthusiasm for working with college-age patients essential: R. B. Rardin, M.D., Director, Student Health Service, Miami University, Oxford, Ohio 45056, phone 513/529-3333.

(Classified Ads continued on page 136.)

FAMILY PRACTICE: Existing general practices need new partners or associates. Top medical community. Excellent general hospital. Offices and cross coverage available. Contact: ROBERT FLINT, Marion General Hospital, MARION, OHIO 43302, telephone: 614/382-8211 or 382-3442 any time.

AMBULATORY CARE— TEACHING HOSPITAL: Excellent opportunity available for INTERNIST interested in full-time primary practice in Southwest Ohio. Income and benefits excellent. Regular hours. Confidentiality assured. Please send resume and requests for further information to: Montgomery County Medical Society, Attn: Mr. Tapia, Fidelity Building, Dayton, Ohio 45402.

PSYCHIATRY STAFF OPENING: Board-eligible or board-certified psychiatrist in a reorganized service of outpatient-inpatient programs with 550 operating psychiatric beds and 40,000 outpatient visits. The environment is healthy; work standards high. An unusual opportunity for personal development and individual contributions to organizational upgrading. USCSC fringe benefits. Nondiscriminating in employment. Send application and resume to Chief of Staff, Paul F. Fletcher, M.D., VA Hospital, Chillicothe, Ohio 45601, phone 614/773-1141.

INTERNIST WANTED: Need additional internal medicine physician. Board qualified. Established group practice in Lakewood, Ohio. Excellent salary. Fringe benefits with full membership in group within one year. Reply Box 815, c/o Ohio State Medical Journal.

AMBULATORY CARE CENTER — EMERGENCY DEPARTMENT STAFF PHYSICIAN, ATHENS, OHIO: 20,000 annual patient visits. Flexible scheduling, minimum guarantee/monthly bonus, excellent fringes. Contact Eric Jenison, M.D., O'Bleness Memorial Hospital, Athens, Ohio 45701, or call toll-free 800/325-3982 for details.

OB/GYN: Established OB/GYN partnership has too much to handle, must expand, add third physician. New facility. Excellent hospital within walking distance. Contact Robert Flint, 614/382-8211 (weekdays) or 614/382-3442, MARION GENERAL HOSPITAL, McKinley Park Drive, Marion, Ohio 43302.

M.D., L.L.B.: Seeks part-time position in Northeast Ohio. Excellent administrative and organizational skills. Write Box 800 Ohio State Medical Journal.

OHIO-LICENSED HOUSE PHYSICIANS: Beginning July 1, 1978 to June 30, 1979, openings in the following departments: Medicine, Surgery, and OB/GYN. 280-bed hospital, suburban location. Excellent benefits including hospitalization, life insurance, fully paid malpractice insurance, and liberal paid vacation. Send complete resume to: Box 817, c/o Ohio State Medical Journal.

GENERAL MEDICAL OFFICES AVAILABLE FOR RENT: In Hartville, reportedly the fastest growing township in Ohio. New construction permitting individual furnishing. Physically attached to Cancer Center with diagnostic x-ray, laboratory, and pharmacy facilities. Contact George N. Swallon Agency, Canton, Ohio, 216/456-3495, or inquire of R. K. Loeffler, M.D., 650 South Prospect, Hartville, Ohio 44632.

FAMILY PRACTICE — RURAL PRACTICE: Northwest/central rural/agrarian community of 1200/1500 needs family practice physician. Practice could expand to cover 3000/3500 population area. No physician now practicing. Community will support. Major regional hospital within driving distance. Contact ROBERT FLINT, MARION GENERAL HOSPITAL, MARION, OHIO 43302, phone 614/382-8211 or 382-3442.

ERPG, INC.— OHIO: Seeking two, young, full-time, career-oriented, emergency room physicians. Salary $60,000 per year. Health and malpractice insurances paid. Partnership in two years. Ohio license required. Send complete curriculum vitae to: Metin M. Ercan, M.D., Mercy Medical Center, Springfield, Ohio 45504.

PROFESSIONAL OFFICE: Warren, Ohio. Approximately 1,000 sq. ft. Off-street parking. Will subdivide to suit tenant. Ideal for general practitioner or internist. Laboratory and surgeon in building. Contact: Physicians & Surgeons Laboratory, 210 Scott St., Warren, Ohio 44483, phone 216/395-3888 or 889-2538.

INTERNAL MEDICINE: Excellent practice, now solo, needs to add an IM physician. Board-qualified mandatory. Excellent community and hospital. Contact Robert Flint, MARION GENERAL HOSPITAL, Marion, Ohio 43302 or phone: 614/382-8211 or 382-3442.

PEDIATRICIAN: Solo or associate practice in city of 40,000. Office space, housing, and excellent 250-bed general hospital with privileges available. Contact: Robert Flint, 614/382-8211 (weekdays) or 614/382-3442, MARION GENERAL HOSPITAL, McKinley Park Drive, Marion, Ohio 43302.



Tired of the Rat Race?

Tired of the crime, the congestion, the tension and frustration of the big city and the big city hospital? Are you running your life or is your life running you?

If the "good life" is eluding you, in your present location, Steuben County in Indiana is worthy of your consideration, as a place to practice medicine and to live.

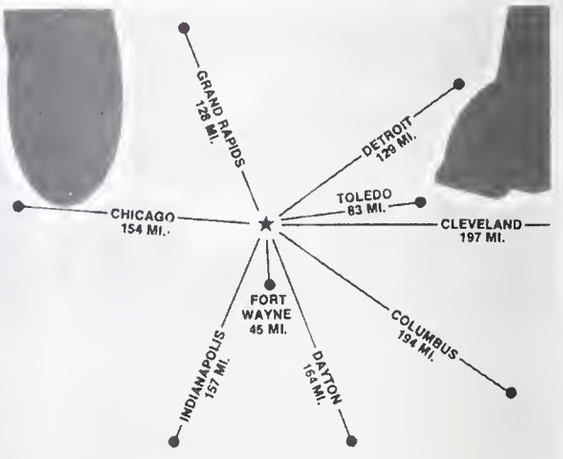
Located in the northeast corner of Indiana, with a population of 22,000, it has a stable economy based on agriculture, light industry and tourism.

Steuben County is endowed with 116 lakes which attract an additional summer population of 100,000 for fishing, other water sports, and general vacationing.

A new, first rate 60 bed hospital is just being completed, with ICU/CCU unit, 24 hour E.R. physician coverage, and facilities for radiographic special procedures, providing an uncomplicated setting in which to practice quality medicine.

This area has 45 minute access to sophisticated medical center and the larger city advantages of Fort Wayne; 3 hour freeway access to Chicago.

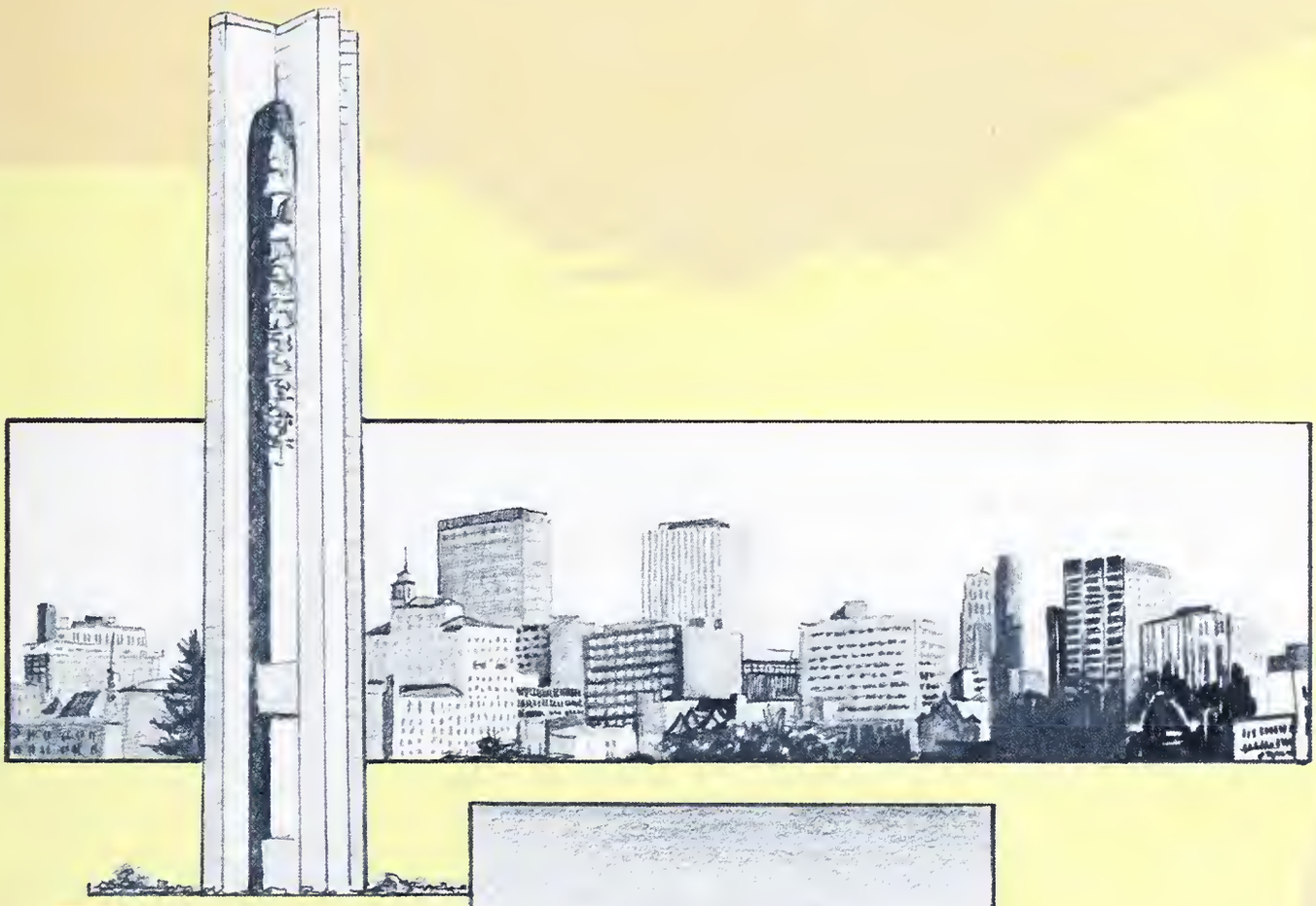
It has many friendly communities, where you can enjoy living and raising a family, which need and want the services of both family practitioners and specialists.



For more information, contact Wendell Jacob, Chairman Physician Recruitment Committee, 15 South Public Square, Angola, Indiana. 46703. (219) 665-3194.

MARCH 1978
Volume 74, Number 3

THE OHIO STATE Medical Journal



CoME to Dayton

OSMA Annual Meeting
May 6-10, 1978



LIBRARY
U.C. SAN FRANCISCO
MAR 31 1978

THE LIBRARY
ACQUISITIONS D
UNIVERSITY OF
SAN FRANCISCO,

PUBLISHED BY THE OHIO STATE MEDICAL ASSOCIATION

PERFORMANCE. PROVEN EFFECTIVENESS WITHIN A WIDE SAFETY MARGIN.



While Roche Laboratories already knows more about the performance of Librium than anyone else, we keep on learning every day.

For example, the highly favorable benefits-to-risk ratio of Librium is a well-documented matter of record.

And, of course, the specific calming action of Librium has been demonstrated in millions of patients around the world. In a large number of these patients, Librium was used concomitantly with other primary medications.

Proven performance within a wide safety margin. Basically, that's what Librium is all about.

LIBRIUM® Ⓘⓥ

chlordiazepoxide HCl/Roche

THE ANXIETY-SPECIFIC

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

ROCHE

Roche Products Inc.
Manati, Puerto Rico 00701

Legislative Update

the state scene

(Courtesy the OSMA Department of State Legislation)

Optometry Bill Referred to House Judiciary Committee Physician Contacts Needed

Senate Bill 163 (Jackson, D-Cleveland) has been referred to the House Judiciary Committee. The importance of early contacts with the members of the Judiciary Committee and local State Representatives cannot be overemphasized.

Because many House members may be completely unfamiliar with SB 163, letter and calls from **physicians of all specialties** are critically needed to inform legislators of the problems associated with permitting nonmedical practitioners to administer dangerous drugs. The Ohio Optometric Association and its members are already telling their side of the story to the members of the House. When SB 163 was in the Senate, physicians did not make the all-important early contacts that are essential to convincing a legislator. There must be no delay in the House.

Letters and contacts should be made on a personal basis. They should be positive and lacking in emotional arguments, with the facts simply stated. Hostile contacts do nothing but harm logical arguments. Physicians should, as briefly as possible, cite the importance of their extensive clinical training in preparing them to diagnose the presence or absence of disease and to deal with drug reactions.

Certificate-of-Need Legislation Moves to House of Representatives

As expected, Substitute Senate Bill 349 (Valiquette, D-Toledo), revisions to Ohio's certificate-of-need laws, was passed by the Senate and sent to the House. The legislation includes review of independent physician purchases of major medical equipment costing over $100,000. Since the bill's introduction, the OSMA has opposed the inclusion of equipment purchases for physicians' offices in the certificate-of-need bill. The bill now goes to the House where it will be referred to the House Finance Committee.

The chairman of the Committee, Myrl Shoemaker (D-Bourneville), and the chairman of the subcommittee considering the bill, Larry Christman (D-Englewood), have told the OSMA that they will review all aspects of the Senate bill with open minds. Although the OSMA has already testified against the companion House bill to SB 349, the OSMA will once again be presenting both staff and physician testimony against the inclusion of the review of physician offices. It is necessary for physicians who wish to give their opinions to their legislators to do so immediately.

Contact should be made with members of the House of Representatives. In these contacts, physicians need to discuss their reasons for objecting to the inclusion of physician purchases of medical equipment costing more than $100,000. The local Health System Agency (HSA) and the areawide health planners are continuing to argue that the inclusion of **all** equipment purchases over $100,000 is necesary to permit effective cost containment and efficient utilization of equipment purchases.

The new certificate-of-need procedures will probably eliminate the possibility of establishing future independent radiology or pathology laboratories. Most HSAs believe that these functions are most efficiently carried out in a hospital. Therefore, certificate-of-need applications for equipment costing over $100,000 for a private physician's office may be turned down on the basis that the equipment is already available at a "local" hospital. Although the federal certificate-of-need regulations do not currently mandate review for physicians' major equipment purchases, a bill introduced on January 19, 1978 would include these purchases in the review process. On February 23, the OSMA and AMA sent a delegation to the U.S. Congress to argue for the removal of physician-equipment purchases from certificate-of-need review. The OSMA continues to oppose SB 349 as long as it includes the review of physicians' office purchases.

Hearing for Public Health Council Certificate-of-Need Rules

The Public Health Council (PHC) of the Ohio Department of Health held a public hearing on its proposed certificate-of-need rules. The OSMA testified that the exclusion of physician offices in the proposed PHC rules "meets both the requirements and the spirit of the federal law." These rules, promulgated in response to a legislative mandate two years ago in HB 908, will implement PL 93-641 in Ohio, assuming that SB 349 does not become law. The proposed certificate-of-need rules were attacked by the health planning agencies. The agencies believe that SB 349 is a better vehicle for implementing PL 93-641, the federal health planning law enacted in 1974.

The proposed rules set an expenditure threshold of $100,000 for any health care facility before a certificate of need becomes necessary. The OSMA testified that the federal limit of $150,000 was more appropriate than $100,000. In addition, the proposed rules include a large part of the National Guidelines for Health Planning as promulgated by the Department of Health, Education, and Welfare. The OSMA objected to the inclusion of these "guidelines" in the certificate-of-need rules because the inclusion would make them mandates. The OSMA is hopeful that the Public Health Council will incorporate OSMA-proposed changes in their rules prior to final adoption.



the federal scene

(Courtesy the OSMA Department of Federal Legislation and the AMA Washington Office)

Health Planning Guidelines

Both the Ohio State Medical Association and the American Medical Association have submitted to the Secretary of Health, Education and Welfare statements of concern over the Secretary's second set of controversial health planning regulations.

At the same time, the OSMA and AMA turned serious attention to H.R. 10460, the Health Planning and Resources Development Amendments of 1978. Congressman Paul Rogers (D-Fla.) introduced the legislation to amend and to expand his original Health Planning and Resources Development Act of 1978— Public Law 93-641.

Congressman Rogers introduced his bill January 19, 1978 and had completed public hearings on it by February 3. The hearings were before the Interstate and Foreign Commerce Subcommittee on Health and the Environment, a Subcommittee chaired by Rogers.

H.R. 10460 was introduced one day before the revised guidelines were published in the *Federal Register* by HEW Secretary Califano. These revisions came as a rebound from the avalanche of more than 55,000 mostly critical statements, plus a unanimous resolution of opposition from the U.S. House of Representatives that followed in the wake of his original regulations published September 23, 1977.

The response took the agency by surprise, and the guidelines were withdrawn to be revised in such form as to be more acceptable. The revised rules are open to comment until March 6, at which time the final regulations will be published.

Califano emphasized that the guidelines are to serve as national standards for local health system agencies and state health planning bodies which must make the final decisions.

The Secretary said HEW's ability to enforce the guidelines is limited to two areas: (1) If a local hospital proceeded with capital expenditures in violation of a state-adopted plan, HEW could withhold funds that are provided for reimbursement of depreciation costs. (2) HEW does have the power to "decertify" local HSAs that completely disregard the guidelines. However, Califano stressed that planning authority rests in local hands.

The revised guidelines include these major standards:

* A maximum of four hospital beds per 1,000 people.
* An average annual occupancy rate of at least 80% for hospitals in a health service area.
* At least a 75% average occupancy rate and at least 1,500 births annually for hospitals that provide care for complicated obstetrical problems.
* No more than four neonatal intensive-and-intermediate-care beds per 1,000 live births.
* A minimum of 20 beds for pediatric units in urban areas.
* Average annual occupancy rate ranging from 65% to 75% for pediatric units, based on their size.
* At least 200 open heart procedures annually in any institution in which open heart surgery is performed for adults, and at least 100 heart operations annually in any institution in which pediatric open heart surgery is performed.
* At least 300 cardiac catheterizations annually in any adult catheterization unit, and at least 150 cardiac catheterization units annually in any pediatric catheterization unit.
* A service area with a population of at least 150,000 people or treatment of at least 300 cancer cases annually, for megavoltage radiation therapy units.
* At least 2,500 procedures per year for each computed tomography scanner.
* Plans consistent with already-established HEW standards and procedures for suppliers of end-stage renal disease services.

Journal Advertisers

Breon Laboratories, Inc. 192
Brown Pharmaceutical Company, Inc. 156, 176, 177
Burroughs Wellcome Co.....146, 147, 151

Daniels-Head & Associates, Inc.....145

Immke Circle Leasing 196

Lilly, Eli and Company 166

Mead Johnson 179, 180
Medical Protective Company.....165

Medical World News 191
Menendian Carpets 190
Merck Sharpe & Dohme.....171, 172
Microtech, Inc. 183

Ohio Medical Indemnity.....186
OSMA Annual Meeting.....185, 194
OSMA MED PREP Program.....189

Pharmaceutical Manufacturers Association 140, 141
Physicians Insurance Company of Ohio....175
Practice Productivity, Inc. 153

Roche Laboratories, Div. of Hoffman-LaRoche, Inc. .....Cover 2, Cover 3, Cover 4

Schmidt's Sausage Haus 174
Smith, Kline and French.....162, 163

Turner and Shepard, Inc.....152

Upjohn Company 148

Warren-Teed Laboratories.....154, 155, 159
Wendt-Bristol Company 145
Windsor Hospital 174

OSMA OFFICERS
President
WILLIAM M. WELLS, M.D.
211 Hudson Avenue
Newark 43055
President-Elect
JOHN J. GAUGHAN, M.D.
7911 Detroit Avenue
Cleveland 44102
Past President
GEORGE N. BATES, M.D.
2102 Shenandoah Road
Toledo 13607
Secretary-Treasurer
ROBERT G. THOMAS, M.D.
630 East River Street
Elyria 44035

EDITORIAL STAFF
Consulting Medical Editor
RICHARD L. MEILING, M.D.
Managing Editor and Business Mgr.
HART F. PAGE
Executive Editor and Executive Business Manager
LINDA A. PORTERFIELD
Editorial Assistant
MARY LOU BRADY
Communications Editor
REBECCA J. DOLL
Continuing Medical Education Editor
GAIL E. DODSON
Ass't. Continuing Medical Education Editor
DAVID C. TORRENS
Federal Legislation Editor
CHARLES W. EDGAR
Field Service Editor
ROBERT E. HOLCOMB
Government Relations Editor
HERBERT E. GILLEN
Health Education Editor
ROBERT D. CLINGER
Membership Editor
KATHERINE E. WISSE
Organization Services Editor
JERRY J. CAMPBELL
State Legislation Editor
D. BRENT MULGREW, ESQ.
Ass't. State Legislation Editor
RICHARD A. AYISH

Address All Correspondence, Address Change, & Reprint Request (unless otherwise noted):
Executive Editor
The Ohio State Medical Journal
600 South High Street
Columbus, Ohio 43215
Phone: 614/228-6971

Published monthly under the direction of The Council for and by members of The Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215, a scientific society, nonprofit organization, with a definite membership for scientific and educational purposes.

1977 Subscription: $10 per year, single copy $1.50 (outside U.S. $13 and $2).

Entered as second class matter July 5, 1905, at the Post Office at Athens, Ohio, under the Act of Congress of March 3, 1879. Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918. Second-Class Postage Paid at Athens, Ohio.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertisers must conform to policies and regulations established by The Council of the Ohio State Medical Association.

Publication office: 900 East State Street, Athens, Ohio 45701.

Printed by
The Lawhead Press, Inc., Athens, Ohio

VOL. 74 MARCH 1978 NO. 3

THE OHIO STATE Medical Journal

Clinical and Scientific Articles

CHEST ROENTGENOGRAPHIC SIGNS OF COLLAGEN VASCULAR DISEASE 142
Ronald J. Scott, M.D., Cleveland

THE STATUS OF IMMUNIZATION OF KINDERGARTEN CHILDREN IN OHIO 149
Thomas J. Halpin, M.D., M.P.H.; James S. Marks, M.D.; John H. Ackerman, M.D., M.P.H.; and John J. Irvin, Columbus

THE NEED FOR LABORATORY IMPROVEMENT IN OHIO 157
John H. Ackerman, M.D., M.P.H., and Charles C. Croft, Sc.D., Columbus

THE INSPECTION AND ACCREDITATION PROGRAM OF THE COLLEGE OF AMERICAN PATHOLOGISTS 160
William A. Hawk, M.D., Cleveland

MANAGEMENT OF SEVERE ATTACKS OF ULCERATIVE COLITIS 167
Sheldon C. Binder, M.D., and Bertram Katz, M.D., Youngstown

THE SELECTION OF CANDIDATES FOR MEDICAL EDUCATION 170
Milton M. Parker, M.D., Ph.D., Columbus

CANCER EDUCATION SERIES: MANAGEMENT OF THE CANCER PATIENT IN THE COMMUNITY HOSPITAL 173
Neal J. Prendergast, M.D., and James C. Maher, M.D., Gallipolis

Special Articles

PRELIMINARY SCHEDULE OF EVENTS AT THE 1978 OSMA ANNUAL MEETING 182

JOHN C. REEVE, M.D., PIONEER DAYTON PHYSICIAN (1826-1920) 187
Katherine T. Barkley, Cincinnati

Features

Legislative Update — State.....137
Legislative Update — Federal...138
Journal Advertisers.....138
Obituaries 147
New Members.....176
News 178
Continuing Education Programs..181
OSMA Placement Service Ads....193
Classified Ads 195

COVER: The OSMA Department of Continuing Medical Education is planning six days of continuing education, interspersed with numerous other activities, for the 1978 OSMA Annual Meeting. The CME program begins May 5 with the opening session of the House of Delegates on Sunday, May 7. Dayton, the site of the meeting, promises much to the visitor, including its skyline, Deeds Carillon, and the United States Air Force Museum, all pictured on the cover. See page 182 for the preliminary schedule of the 1978 OSMA Annual Meeting.

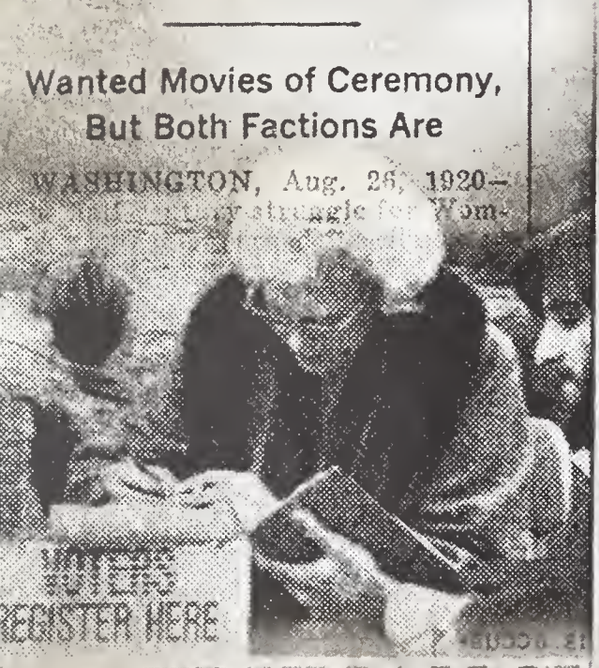
COLBY PROCLAIMS WOMAN SUFFRAGE

Signs Certificate of Ratification at His Home Without Women Witnesses.

MILITANTS VEXED AT PRIVACY.

Wanted Movies of Ceremony, But Both Factions Are

WASHINGTON, Aug. 26, 1920—



Social Security Bill Is Signed; Gives Pensions to Aged, Jobl

Roosevelt Approves Message Intended to Benefit 30,000 Persons When States Adopt Cooperating Laws–He Ca the Measure 'Cornerstone' of His Economic Program

WASHINGTON, Aug. 14, 1
The Social Security Bill, prov
a broad program of unemploy
insurance and old age pen
and counted upon to benefit
20,000,000 persons, became la
day when it was signed by P
dent Roosevelt in the presen
those chiefly responsible for
ting it through Congress.

Mr. Roosevelt called the me
"the cornerstone in a stru
which is being
me s comple
ti o

COM

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today, 94 to 0, and sent to

TRUMAN CLOSES TED NATIONS CONFEREN ITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

IGNE

the Draf Ends No

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after re-



PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA
THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION
1155 FIFTEENTH ST. N. W. WASHINGTON, D. C. 20005

THE OHIO STATE Medical Association Clinical and Scientific

Chest Roentgenographic Signs of Collagen Vascular Disease

Ronald J. Scott, M.D.

Connective tissue disease or collagen vascular disease are terms used to describe multisystem entities of diverse etiology often presenting the physician with difficult diagnostic problems. Pulmonary involvement is not at all uncommon in these disorders, and it may take many forms on the chest roentgenogram. This review attempts to define the varied roentgenographic patterns of some of these diseases.

SYSTEMIC LUPUS ERYTHEMATOSIS (SLE) is a multisystem disease with major manifestations in the vascular and epidermal systems as well as the serous and synovial membranes. Pulmonary involvement occurs in the majority of patients.[1,2] Seven to 11 percent of them contract an acute form of pneumonitis. They become severely short of breath with tachypnea, fever, and rales. Pleuritic pain occurs in 50 percent, but the white blood count seldom rises above 12,500 per cu mm. The chest roentgenogram shows an acinar or alveolar filling pattern indistinguishable from a consolidating pneumonia. The infiltrates are usually — but not always — bilateral and are often migratory, ie, one nonsegmental area of involvement clears as another develops an infiltrate. About half of them show evidence of concurrent pleural effusion.[1] Some have found corticosteroid therapy to be helpful in acute pneumonitis, and if the patient is already taking steroids, dosage probably should be increased. When steroid therapy fails, azathioprine, 2.5 mg/kg, has been reported to hasten resolution time significantly.[1,3] Acute pneumonitis can lead to chronic lupus pneumonitis in either a symptomatic form or in a degree manifested only by abnormal pulmonary function testing.

There are many manifestations of chronic pulmonary lupus, including pleural thickening, pleural effusion, unilaterally elevated diaphragm, small lung volumes, parenchymal reticulonodular infiltrates, supradiaphragmatic atelectasis, long-line shadows, and cardiac involvement.[2,4,5] Parenchymal reticulonodular interstitial disease is quite rare, usually involving the basal segments bilaterally. This form is indistinguishable from interstitial involvement in the other collagen vascular diseases, and it can remit spontaneously. Quite characteristic of SLE are small lung volumes shown on chest roentgenogram. This is due presumably to vascular involvement leading to atelectasis and volume loss, in addition to some restriction due to fibrinous pleural reaction. Vascular involvement is also responsible for the linear atelectasis and the long-line shadows of Simon (Fig. 1).[6] Pleural effusion, very common in lupus, is exudative, has a low total complement level, but is otherwise not characteristic. A transudative effusion may indicate hypoalbuminemia secondary to lupus nephrosis. Corticosteroids are of little effect in the chronic state, and pulmonary histology is nonspecific unless hematoxylin bodies are seen.

Unusual pulmonary manifestations of SLE include hilar adenopathy,[7] massive hemoptysis,[8] and pulmonary hypertension without evident parenchymal disease.[9] The drug-induced lupus syndromes also can involve the lung and are notably responsible for pleuritic pain and pleural effusion. The lack of renal involvement and a normal pleural fluid complement are typical of this syndrome, most commonly seen with procainamide.[10]

Polymyositis-Dermatomyositis

Pulmonary involvement in polymyositis or dermatomyositis, unlike SLE, is a rare entity. However, it too can present as both acute and chronic pulmonary disease.

Dr. Scott, formerly Fellow in Pulmonary Medicine, University of North Carolina School of Medicine, Chapel Hill, N.C., is currently in private practice in Cleveland and on the Active Staffs of Lakewood and Fairview General Hospitals.

Submitted May 25, 1977.

As in lupus, the patient may be quite ill with acute pneumonitis, developing fever, dyspnea, cough, and bibasilar, interstitial infiltrates.[11,12] Pathologically, there is evidence of acute inflammation without fibrosis, usually responding to steroid therapy.[13]

Chronic pneumonitis is insidious in onset and involves the lung diffusely with a fine interstitial process, in some cases prior to muscular symptoms. Organized fibrosis is evident pathologically making therapeutic response unusual.[11,12] There is no pleural involvement clinically or roentgenographically although some fibrous pleurisy may be seen histologically.[13]

In addition to primary pulmonary involvement, the lung may become secondarily involved with aspiration pneumonitis due to pharyngeal and upper-esophageal muscular involvement. The chest wall musculature also may become involved, leading to aveolar hypoventilation, retention of secretions, and atelectasis.



FIG. 1. Anteroposterior chest roentgenogram with evident basilar atelectasis and long-line shadows in patient with systemic lupus erythematosis.

Scleroderma

Progressive systemic sclerosis is a well-known multisystem disease with manifestations in nearly every organ of the body. Pulmonary involvement documented histologically occurs in nearly all patients.[14] Even in the asymptomatic, abnormalities in exercise testing or diffusion capacity suggest early parenchymal or vascular disease.[15] Interstitial disease is the predominate finding in systemic sclerosis. In the early stages, a fine, reticular pattern predominates the lower lung roentgenographically, followed by coarsening and finally, a honeycomb pattern at the lung bases (Fig. 2).[16] Small, coarse nodules can occur at the bases and can calcify occasionally.

Pleural changes are uncommon clinically, as is pleural effusion, but pathologic evidence of fibrous adhesions are frequent.[17] An interesting feature of scleroderma in the lung is the frequency of roentgenographically visible, subpleural cysts and attendant spontaneous pneumothorax.

Pulmonary hypertension can occur with or without radiologic or pathologic interstitial disease.[15,18] Myxomatous intimal lesions in small vessels predominate the pathologic picture. Enlarged major pulmonary vasculature with early peripheral tapering accompanied by dyspnea on exertion and normal spirometry and lung volumes should suggest pulmonary hypertension.

Systemic sclerosis also has been said to be associated with a higher incidence of lung cancer, especially alveolar cell carcinoma. As in dermatomyositis, aspiration may complicate the picture due to involvement of the smooth muscle in the lower two-thirds of the esophagus, responsible for the motility disorder so common to scleroderma. An air-filled, dilated esophagus shown on lateral chest roentgenogram might lead to such a diagnosis.[16]



FIG. 2. Chest roentgenogram of patient with end-stage scleroderma, demonstrating a honeycomb pattern predominant at lung bases.

Rheumatoid Arthritis

Pleuropulmonary rheumatoid disease can be categorized into five areas of involvement: diffuse interstitial

fibrosis, pleural effusion, macronodules, Caplan's syndrome, and pulmonary arteritis.

Diffuse interstitial fibrosis occurs in only about 2 percent of rheumatoid arthritics.[19] It can assume the form of a fine, minute, nodular pattern similar to miliary tuberculosis, later evolving into coarse, interstitial infiltrates or honeycombing. The course is unpredictable, however, and the patient may be asymptomatic for years. Steroid therapy has been used to improve exercise tolerance and the roentgenographic picture in some, but the effect is temporary.[19]

Pleural disease is the most common of the thoracic manifestations of rheumatoid arthritis. It is painful in about 30 percent of the patients and is characterized in a majority by an effusion glucose level under 30 mg per 100 ml. The effusion is a lymphocytic exudate and may be either unilateral or bilateral. It is not associated with the severity of the arthritis, but rather with high titers of rheumatoid factor and systemic, subcutaneous nodules. An important feature is that the effusion may resolve itself slowly over months or remain essentially unchanged for years.[19,20] Steroids administered systemically may hasten resolution. With pleural adhesions not uncommon, loculated fluid may be seen.

Necrobiotic nodules in the lung are pathologically identical to the subcutaneous nodules in the skin. An area of central necrosis is surrounded by palisading young fibroblasts, in turn enclosed by a cellular or sclerotic reaction. Roentgenographically, the nodules occur bilaterally, vary in size, often cavitate and may either increase in size or disappear as the disease remits. They also are associated with subcutaneous nodules and high titers of rheumatoid factor. Figure 3 illustrates the occurrence of multiple nodules over an underlying, interstitial fibrosis in rheumatoid arthritis. If the nodules are subpleural in location, they may rupture and lead to the described higher incidence of empyema in rheumatoid arthritis.[21]

Caplan's syndrome is the occurrence of similar parenchymal nodules in arthritics at risk for silicosis, asbestosis, or coal workers pneumoconiosis. A dark, concentric dust ring surrounding their necrotic center differentiates the occupational associations from the simple necrobiotic nodule.[22] The nodules appear in crops quite rapidly and can cavitate. There is no known association with severity of arthritis and the presence of the nodules.

Pulmonary hypertension and consequent cor pulmonale, as in scleroderma, can be the sole manifestation of rheumatoid disease. A fibroelastoid, intimal proliferation is responsible for vascular occlusion and pulmonary hypertension. All cases have occurred in association with Raynaud's syndrome, implying a similar pathogenesis.[19]

Summary

The collagen vascular diseases discussed here present the internist with a wide variety of interesting yet therapeutically difficult pulmonary problems. The findings on chest roentgenogram are seldom specific for any of the diseases covered, but a knowledge of the varied manifestations enables the physician to arrive at a reasonable diagnosis in most cases.



FIG. 3. Interstitial disease, predominant at bases, accompanies three distinct rheumatoid nodules (arrows) proved pathologically.

References

1. Matthay RA, Schwarz, MI, Petty TL, et al: Pulmonary manifestations of systemic lupus erythematosis: a review of twelve cases of acute lupus pneumonitis. *Medicine* **54**: 397-409, 1975.
2. Eisenberg H, Dubois EL, Sherwin RP, et al: Diffuse interstitial lung disease in SLE. *Ann Intern Med* **79**:37-45, 1973.
3. Matthay RA, Petty T: Letter: Treatment of acute lupus pneumonitis with azathioprine. *Chest* **66**:219-220, 1974.
4. Levin DC: Proper interpretation of pulmonary roentgen changes in systemic lupus erythematosis. *Am J Roent Radium Ther Nucl Med* **111**:510-517, 1971.
5. Bulgrin JG, Dubois EL, Jacobson G: Chest roentgenographic changes in systemic lupus erythematosis. *Radiology* **74**:42-49, 1960.
6. Simon G: Further observations on the long line shadow across a lower zone in the lung. *Br J Radiol* **43**:327-332, 1970.
7. Kassan SS, Moss ML, Reddick RL: Progressive hilar and mediastinal lymphadenopathy in systemic lupus erythematosus on corticosteroid therapy. *N Engl J Med* **294**: 1382-1383, 1976.
8. Gould DB, Soriano RZ: Acute alveolar hemorrhage in lupus erythematosus. *Ann Intern Med* **83**:836-837, 1975.
9. Wohl MJ: Differential diagnosis, in article, Castleman B, et al, Case records of the Massachusetts General Hospital. *N Engl J Med* **288**:204-210, 1975.
10. Blomgren SE, Condemi JJ, Vaughan JH: Procainamide-

induced lupus erythematosis. *Am J Med* 52:338-342, 1972.
11. Frazier AR, Miller RD: Interstitial pneumonitis in association with polymyositis and dermatomyositis. *Chest* 65:403-407, 1974.
12. Duncan PE, Griffin JP, Garcia A, et al: Fibrosing alveolitis in polymyositis: a review of histologically confirmed cases. *Am J Med* 57:621-626, 1974.
13. Schwarz MI, Matthay SA, Sahn RE, et al: Interstitial lung disease in polymyositis and dermatomyositis: analysis of six cases and review of the literature. *Medicine* 55:89-104, 1976.
14. Bader RA, Bader ME: Thoracic manifestations of collagen diseases, in *Textbook of Pulmonary Diseases,* Baum GL, ed, Boston, Little Brown & Co, 1974, pp 459-481.
15. Sackner MA, Akgun N, Kimbel P, et al: The pathophysiology of scleroderma involving the heart and respiratory system. *Ann Intern Med* 60:611-630, 1964.
16. Fraser RG, Pare JAP: *Diagnosis of Diseases of the Chest.* Philadelphia, W. B. Saunders, 1970, p 890.
17. Weaver AL, Divertie MB, Titus JL: Pulmonary scleroderma. *Dis Chest* 54:490-498, 1968.
18. Kazemi H: Differential diagnosis, in article, Castleman B, McNeely BU: Case records of the Massachusetts General Hospital. *N Engl J Med* 286:91-99, 1972.
19. Walker WC, Wright V: Pulmonary lesions and rheumatoid arthritis. *Medicine* 47:501-520, 1968.
20. Campbell GD, Ferrington E: Rheumatoid pleuritis with effusion. *Dis Chest* 53:521-527, 1968.
21. Jones FL Jr, Blodgett RC Jr: Empyema in rheumatoid pleuropulmonary disease. *Ann Intern Med* 74:665-671, 1971.
22. Morgan WK, Lapp NL: Respiratory disease in coal miners. *Am Rev Respir Dis* 113:531-539, 1976.

MEDICAL/SURGICAL PRODUCTS
LABORATORY PRODUCTS
SPECIALTY PRODUCTS
PHARMACEUTICALS
PATIENT AIDS
INSTRUMENTS
FURNITURE

THE WENDT-BRISTOL COMPANY
1159 DUBLIN ROAD
COLUMBUS, OHIO 43215
614/486-9411

we can provide some form of health insurance to . . .

99%

of OSMA members—regardless of health history

Comprehensive protection is available for you and your family with the OSMA sponsored Hospital Confinement Insurance Plan, comprehensive Major Medical Insurance and the Excess Major Medical Insurance Plan. Also available to Ohio physicians are Disability Income Coverage, Practice Overhead Expense Coverage, Life Insurance and Accidental Death, Dismemberment and Disability Insurance. Choose the plans that fill your insurance needs and send the coupon today for complete details. Or better yet for immediate information, call us collect!

Spencer W. Cunningham
DANIELS-HEAD & ASSOCIATES, INC.
Daniels-Head Building
Portsmouth, Ohio 45662
Telephone 614/354-4561

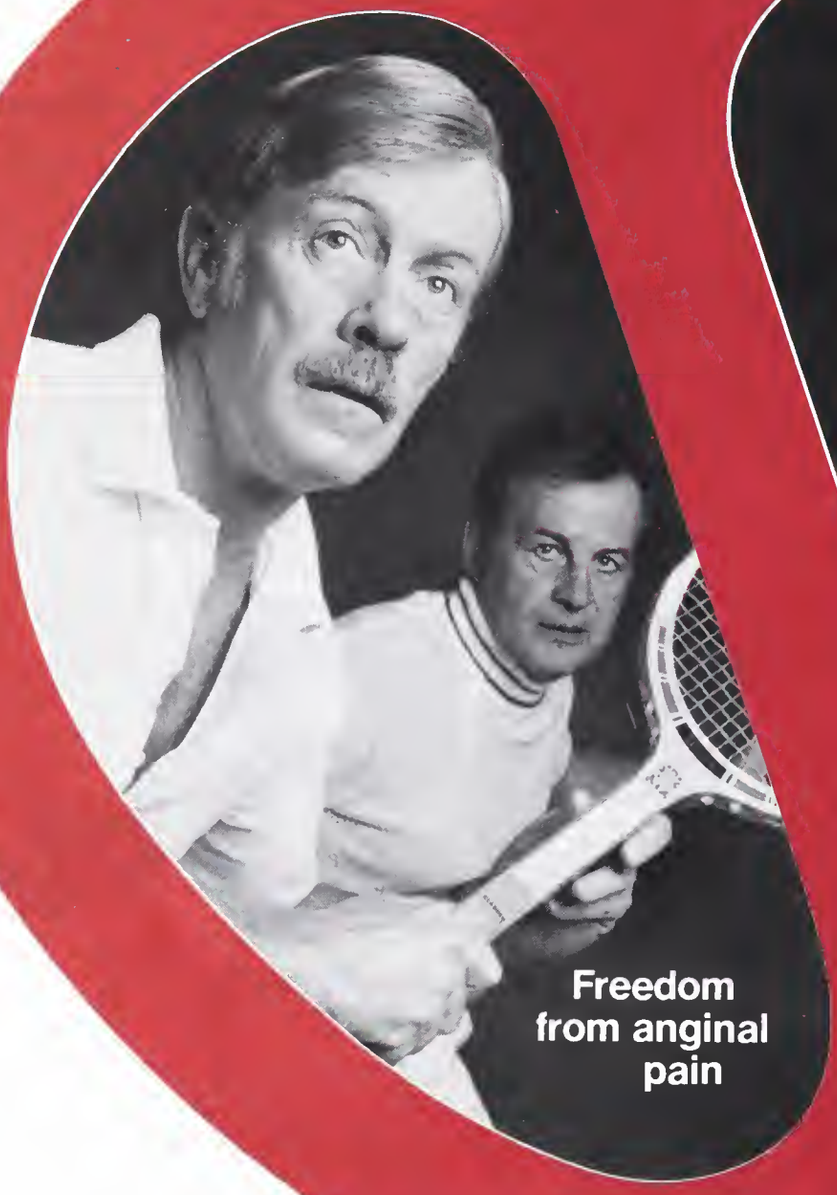
I have checked the plans in which I am most interested. Please send me complete details on how I can take advantage of this high value insurance protection at low group rates.

OSMA SPONSORED PLANS
☐ HOSPITAL CONFINEMENT INSURANCE PLAN
☐ COMPREHENSIVE MAJOR MEDICAL INSURANCE
☐ EXCESS MAJOR MEDICAL INSURANCE

ALSO AVAILABLE TO OHIO PHYSICIANS
☐ DISABILITY INCOME PROTECTION
☐ ACCIDENTAL DEATH, DISMEMBERMENT and DISABILITY INSURANCE
☐ PRACTICE OVERHEAD EXPENSE PROTECTION
☐ LIFE INSURANCE

Name_____
Address_____
City_____
State_____ Zip_____

Angina freedom fighter...



Freedom from anginal pain



Freedom from anginal fear

1. Taken sublingually, Cardilate® (erythrityl tetranitrate) begins to work within 5 minutes, eliminating or reducing frequency and severity of anginal pain for up to two hours.
2. Fear of pain, a major deterrent to achieving acceptable (and desirable) levels of activity, including sex, may be allayed with Cardilate. Effective prophylaxis and improved exercise tolerance help toward normalizing the lives of anginal patients.

Cardilate®
(erythrityl tetranitrat

Cardilate® (erythrityl tetranitrate)
INDICATIONS: For the prophylaxis and long-term treatment of patients with frequent or recurrent anginal pain and reduced exercise tolerance associated with angina pectoris, rather than for the treatment of the acute attack of angina pectoris, since its onset is somewhat slower than that of nitroglycerin.

PRECAUTIONS: As with other effective nitrites, some fall in blood pressure may occur with large doses

Caution should be observed in administering the drug to patients with a history of recent cerebral hemorrhage, because of the vasodilation which occurs in the area. Although therapy permits more normal activity, the patient should not be allowed to misinterpret freedom from anginal attacks as a signal to drop all restrictions.

SIDE EFFECTS: No serious side effects have been reported. In sublingual therapy, a tingling sensation (like that of nitroglycerin) may sometimes be noted at the point of tablet contact with the mucous membrane. If objectionable, this may be mitigated by placing the tablet in the buccal pouch. As with nitroglycerin or other effective nitrites, temporary vascular headache may occur during the first few days of therapy. This can be controlled by temporary dosage reduction in order to allow adjustments of the cerebral hemodynamics to the initial marked cerebral vasodilation. These headaches usually disappear within one week of continuous therapy but may be minimized by the administration of analgesics.

Mild gastrointestinal disturbances occur occasionally with larger doses and may be controlled by reducing the dose temporarily.

HOW SUPPLIED: 10 mg chewable scored tablets, bottle of 100. Also 5, 10 and 15 mg oral/sublingual scored tablets in bottles of 100. 10 mg oral/sublingual scored tablets also supplied in bottles of 1,000.

Also available: Cardilate®-P brand Erythrityl Tetranitrate with Phenobarbital* Tablets (Scored).

(*Warning—may be habit-forming.)



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709
Wellcome

Ohio State Medical Association Obituaries

JESSE H. BOND, M.D., Akron; Jefferson Medical College of Thomas Jefferson University, 1933; age 77; died December 5, 1977; member OSMA and AMA.

DANIEL E. BRANNEN, M.D., Dayton; Jefferson Medical College of Thomas Jefferson University, 1945; age 58; died January 1978; member OSMA and AMA.

SAMUEL D. EDELMAN, M.D., Cleveland; Ohio State University College of Medicine, 1914; age 86; died December 22, 1977; member OSMA and AMA.

GEORGE O. HOSKINS, M.D., Monroe, La.; Ohio State University College of Medicine, 1917; age 86; died December 26, 1977; member OSMA and AMA.

JOHN A. McNAMARA, M.D., Marion; Loyola University Stritch School of Medicine, Maywood, 1933; age 70; died December 22, 1977; member OSMA and AMA.

A. P. PANAGOPOULOS, M.D., Painesville; Faculty of Medicine, National University, Athens, Greece, 1954; age 60; died December 5, 1977; member OSMA and AMA.

JEROME N. RINI, M.D., Cleveland; University of Louisville School of Medicine, 1923; age 83; died December 20, 1977; member OSMA and AMA.

WILLIAM E. SAG, M.D., Alliance; Orvosi Fakultasa Tudomanyegyetem, Debrecen, Hungary, 1932; age 69; died December 15, 1977; member OSMA and AMA.

JAMES R. SCHEIP, M.D., Worthington; University of Cincinnati College of Medicine, 1945; age 57; died December 16, 1977; member OSMA and AMA.

ROBERT R. SCHWALENBERG, M.D., Tiffin; University of Rochester School of Medicine & Dentistry, 1952; age 58; died December 28, 1977; member OSMA and AMA.

LEONARD G. STEUER, M.D., Cleveland; Western Reserve University School of Medicine, 1923; age 77; died December 21, 1977; member OSMA and AMA.

GEORGE T. SZABOKY, M.D., Youngstown; Orvosi Fakultasa Tudomanygeyetem, Budapest, Hungary, 1954; age 49; died December 22, 1977; member OSMA and AMA.

WALTON H. WILLIAMS, M.D., Middletown; Cleveland-Pulte Medical College, 1905; age 95; died January 3, 1978; member OSMA and AMA.



Tolinase®
tolazamide, Upjohn

Please contact your Upjohn representative for additional product information.

Upjohn

J-5695-6

©1977 THE UPJOHN COMPANY

The Status of Immunization of Kindergarten Children in Ohio

Thomas J. Halpin, M.D., M.P.H.
James S. Marks, M.D.
John H. Ackerman, M.D., M.P.H.
John J. Irvin

Recent outbreaks of vaccine-preventable diseases have highlighted the need for increased emphasis on childhood immunization. A survey of Ohio's 152,395 kindergarten pupils revealed that 86% had at least four diphtheria-pertussis-tetanus (DPT) and three poliomyelitis immunizations, as well as one each for measles and rubella. There were wide variations between counties; the highest rate of immunization of children was 97% and the lowest only 57%. Some major metropolitan counties and rural southeastern counties had the lowest rates. Further studies indicated that private physicians immunized over 80% of preschool children, but almost 25% were not immunized adequately. However, with one additional patient visit, two thirds of these children could meet the state immunization requirements.

THE DECREASE IN THE RATES of childhood vaccine-preventable diseases has been one of the greatest triumphs of preventive medicine in the past few decades. With the introduction of each new antigen, large numbers of children became immunized very promptly. The usual method was to encourage mass immunization campaigns which were supported by both public and private medicine. At the onset, these programs were bathed with the optimism that such diseases would no longer pose a threat to the modern child, however, this promise of disease eradication has remained unfulfilled. While large segments of the childhood population became immunized during the mass campaigns, insuring a continuous rise in the immunization rates has become very difficult over the ensuing years (Fig. 1). The need for increased levels of immunization can be seen by the large outbreaks of measles that occurred in the nation and Ohio during 1977.[1]

Dr. Halpin, Columbus, Director, Bureau of Preventive Medicine, Ohio Department of Health; and Assistant Clinical Professor of Preventive Medicine, The Ohio State University College of Medicine.
Dr. Marks, Columbus, Communicable Disease Division, Ohio Department of Health.
Dr. Ackerman, Columbus, Director, Ohio Department of Health; and Assistant Clinical Professor of Preventive Medicine, The Ohio State University College of Medicine.
Mr. Irvin, Columbus, Immunization Program Coordinator, Ohio Department of Health.
Submitted January 19, 1978.

Because of these outbreaks and the realization that immunization levels appear to be lagging, governmental agencies working with all health care personnel have been asked to exert a special immunization effort over the next two years. This effort will be unlike previous mass programs in both scope and content. The importance of all the immunizing antigens will be emphasized, and there will be direction toward a continuing, constant effort rather than a one-shot, mass program.

To better define the immunization problem in Ohio, the Ohio Department of Health will complete three immunization surveys between the fall of 1977 through the spring of 1978. These surveys are intended to target problem areas, to better define reasons for the failure of children to get immunized, and allow evaluation of future remedial programs. This article will concentrate on the immunization status of children entering kindergarten. Other surveys yet to be completed will review the immunization status of 2-year-old children and the status of the school population from grades 1 through 12.

Materials and Methods

On August 29, 1977, a memorandum signed by the Director of Health and the Superintendent of Public Instruction, State of Ohio, was sent to health commissioners, medical societies, and local school superintendents. It concerned a total immunization assessment of the state's 152,395 public school kindergarten pupils in the state's 647 local school districts. The memorandum requested that the school superintendents forward information on the immunization status of their kindergarten pupils to the Ohio Department of Health by October 15, 1977. This summary was submitted on a form prescribed by the Ohio Department of Health.

At the local schools, these reports were completed by the principal of each school or someone designated by him, usually the school health nurse. The form called for a name listing of those not in compliance with the state's immunization law and the type of deficiency of each noncomplying pupil. It also noted if there was a record on file for that particular pupil. These listings were kept on file at each school. A summary of the total number of pupils with deficiencies and the type of deficiency, but without naming the pupil, then was sent by the principal

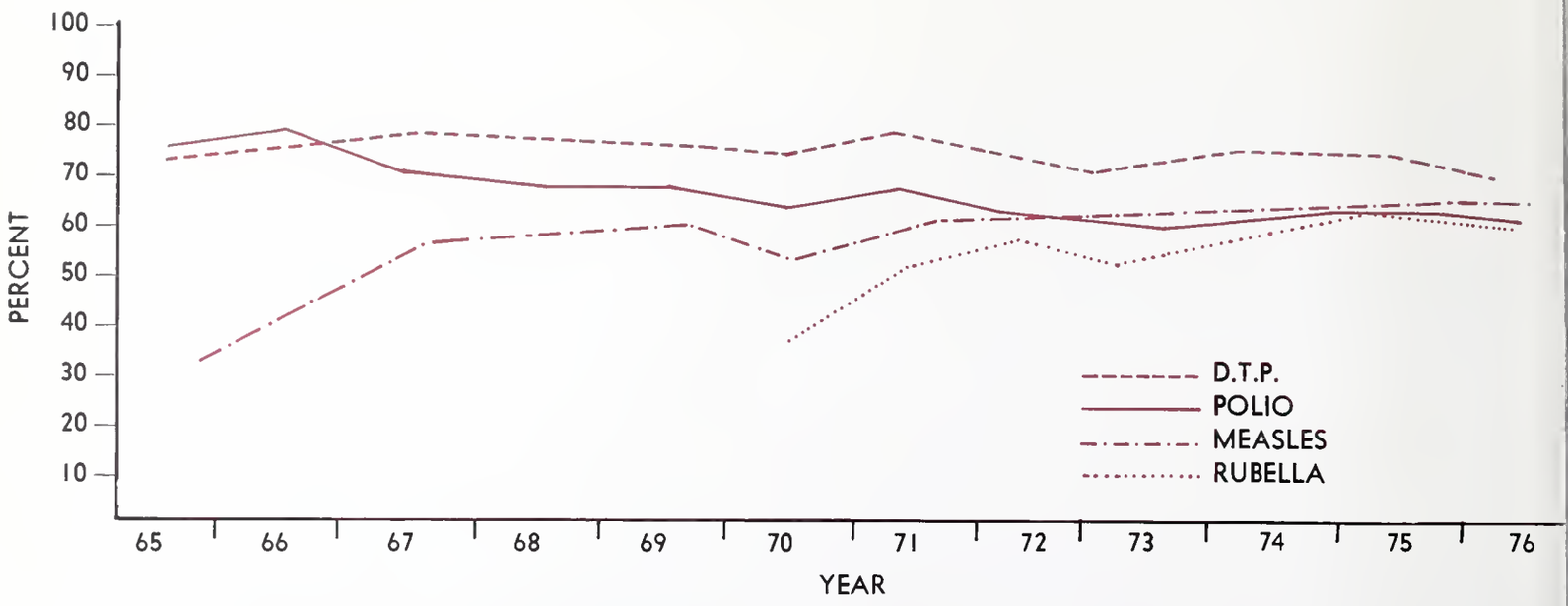


Fig. 1. National immunization status of children 1 to 4 years old. Data from U.S. Immunization Survey 1976 and Center for Disease Control 1977.

via the local superintendent to the Ohio Department of Health.

The original mailing to the local school superintendents was made in early September 1977. By October 15, approximately 75% of the superintendents had mailed their respective school reports to the Ohio Department of Health. On October 17, the staff for the immunization program began telephoning the 150 superintendents who had not responded. By November 1, the program staff had received the last of the reports; 100% of all public school districts had reported.

During November and early December, the program staff prepared computer printouts listing the immunization rates by county, school district, and local school. Appropriate computer printouts then were mailed to local health commissioners, county school superintendents, local medical and osteopathic societies, and the state's ten health systems agencies.

A memorandum signed by the Director of Health accompanied the printouts. This memorandum included a listing by county of pertinent data and ranked each county, based on its kindergarten population size, immunization rate, and the number of pupils not immunized. The memorandum also called for immediate exclusion from school of any kindergarten pupil who had not yet provided acceptable written evidence that the pupil is now immune to measles and rubella and has received at least one diphtheria-pertussis-tetanus (DPT) and one poliomyelitis immunization. The only allowable exceptions were pupils who had written evidence of a medical or religious/philosophical exemption. It was stressed that pupils who were in the process of completing the DPT and polio series must do so in a timely manner.

Results

The completed survey showed that 130,636 of the state's 152,395 kindergarten children were in compliance with the school immunization law. Compliance was based on the child having received at least four DPT, three polio, a rubella, and a measles immunization. These requirements are somewhat more lenient than those recommended by the American Academy of Pediatrics. That Academy recommends that by the time the child reaches kindergarten age, it should have had five DPT, four polio and one each of measles, rubella, and mumps immunization. A medical and religious/philosophical exemption was requested by only 640 pupils, less than one-half of 1% of the kindergarten population.

The data generated through this survey was by school district, however, it has been compiled into data by county for easy visualization (Fig. 2). Although immunization



Fig. 2. Immunization rates of Ohio kindergarten children rated by county — October 1977.

evels varied throughout the state, and even within individual counties, certain problem areas could be pinpointed. In general, the major metropolitan areas and the southeastern counties had poorer levels than the remainder of the state (Fig. 3). Striking contrasts were seen among contiguous counties (Table 1). The reasons for the differences in immunization rates between these county pairs are now under investigation.



FIG. 3. Ohio counties with kindergarten immunization rates below the state average (86%) October 1977.

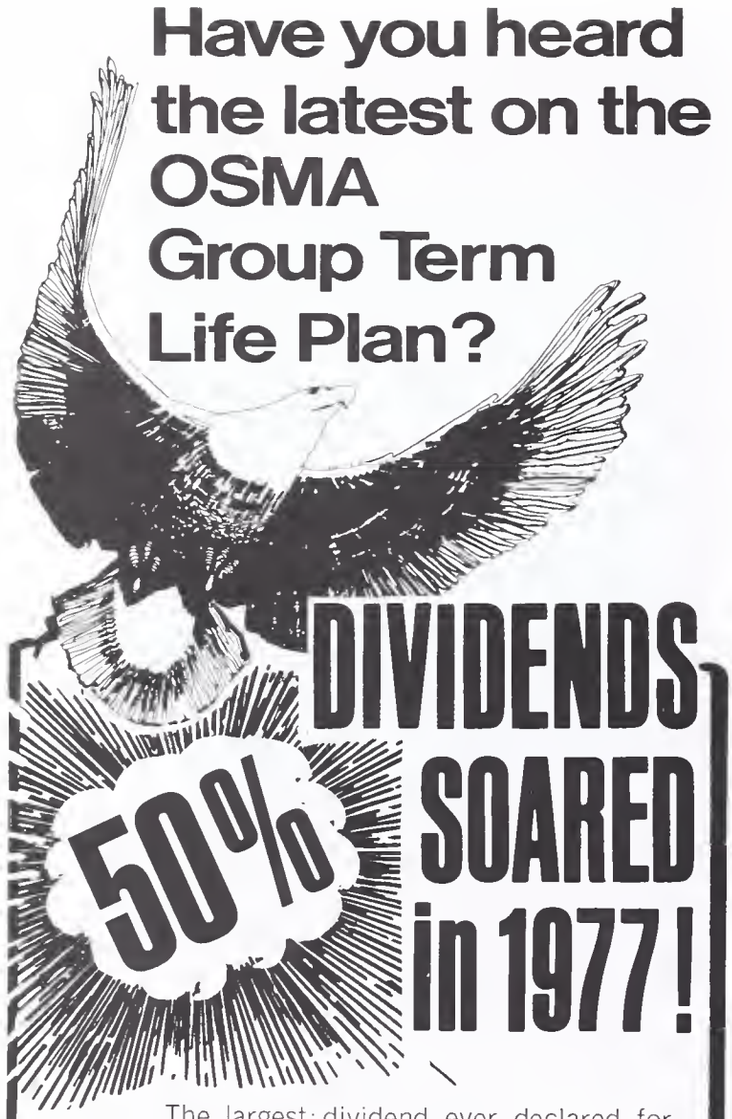
TABLE 1. Contiguous County Pairs with Wide Variations in Immunization Rates

County	%
Brown	94
Adams	80
Athens	90
Meigs	57
Van Wert	93
Mercer	73

In all, 29 of the 88 counties were below the state average of 86% of kindergarten children properly immunized. In these counties, frequently one or two districts with very low immunization levels would lower the county average. Large metropolitan counties frequently were below average because of the low immunization status related to the large city school districts. The lack of immunization records for large numbers of pupils further reduced the immunization rates in the large city school districts. In general, suburban school districts were well immunized, and this helped to increase each metropolitan county's rate.

(continued on page 152)





The largest dividend ever declared for the OSMA Group Term Life Insurance Plan was recently announced for the policy year ending August 31, 1977. This dividend* of 50 per cent was large enough to pay **in full** the March 1st semi-annual premium for participating members.

If you're not insured through the OSMA Group Term Life Plan, YOU'RE PAYING TOO MUCH FOR LIFE INSURANCE!

For information on how to enroll, call your administrator today at one of the 5 offices listed!

* Dividends are not guaranteed.

TURNER SHEPARD

Columbus, Ohio 43215	17 South High Street	Phone (614) 228-6115
Akron, Ohio 44313	3090 West Market Street	Phone (216) 434-5000
Cincinnati, Ohio 45241	4015 Executive Park Drive	Phone (513) 563-4220
Cleveland, Ohio 44134	1440 Snow Road	Phone (216) 741-4466
Toledo, Ohio 43606	3450 West Central Avenue	Phone (419) 535-0616

Discussion

Even though data collected in the survey was by school district, these children are first-entrance children and, therefore, their rate of immunization reflects the status of the health care delivery system within each area, rather than the enforcement policy of the local school district. More recent information indicates that many districts have enforced the school immunization law vigorously. For instance, statistics from the Columbus and Toledo school systems indicate there has been significant improvement in the immunization status of this year's kindergarten class (Table 2). The Ohio Department of Health, along with local health departments, will continue to work with school districts to improve immunization rates during 1978. Further studies should better delineate the reason why certain areas have low immunization rates and why there is a failure to keep the child's immunization status up to date.

TABLE 2. Improvement in Immunization Rates

Schools	Oct. 1977 %	Dec. 1977 %
Columbus	74	93
Toledo	66	88

Preliminary data from the immunization survey conducted on 2-year-old children indicates that Ohio's private physicians immunized over 80% of all preschool children. However, 25% of these children who were under a private physician's care are not adequately immunized. This is similar to the data found when various groups of practicing physicians in Idaho audited their immunization records.[2] Both the kindergarten survey and the preliminary data from this survey of 2-year-old children used immunization criteria that were less stringent than the criteria recommended by the American Academy of Pediatrics. If these more stringent criteria were used, the percentage of inadequately immunized children would increase dramatically. This data points to the immense importance of the pediatrician and family physician in immunizing children in Ohio. It also indicates that both public and private medicine have a long way to go before solving the childhood immunization problem. One good sign is that two-thirds of the improperly immunized children could become properly immunized by only one additional visit to the health care provider. This means that just a little extra effort can affect a great improvement in the immunization status of children in this state.

References

1. Halpin TJ, Marks JS, Ackerman JH: Measles in Ohio - update. *Ohio State Med J* **73**:147-149, 1977.
2. McDaniel DB, Patton BA, Mather JA: Immunization activities of private-practice physicians: a record audit. *Pediatrics* **56**:504-507, 1975.

There is a better way to do it... You can find it!

Two New Books Now Available -

PERSONNEL POLICIES AND PROCEDURES FOR THE MEDICAL OFFICE

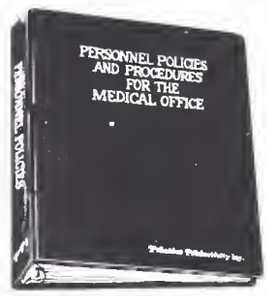
Do you have personnel policies? Are they written? Are they up to date? Do they provide a clear, concise, competitive statement of what you offer and what you expect from your employees? Are your policies within the guidelines of recent legislation?

- Tells the employee what to expect on these important topics:

Working hours	Personal appearance	Vacation	Outside employment
Holidays	Personal phone calls	Housekeeping	Personal medical care
Smoking	Civic responsibilities	Parking	Compassionate leave

- Reviews policy topics for the manager in depth.
- Prewords sample policies for you on 23 topics.
- Makes you aware of many employer obligations such as:

Sick leave	Medical &	Salary	Summary dismissal
Personal days	dental appointments	Discipline	Other benefits
Probation	Performance review	Termination	Leave of absence



AN EASY WAY TO WRITE PERSONNEL POLICIES!

*

APPOINTMENT SCHEDULING THAT WORKS!

A course in appointment scheduling that enables your medical assistant to rebuild your scheduling system – according to the way you work.

- Your appointment employee learns about your real problems as she explores the improvements.
- The resulting schedule is custom designed for your specialty – the way you do things.
- Respects the patient's time. Keeps him from waiting more time than is reasonable - (usually 20 - 30 minutes maximum).
- Begin getting home on time.
- The workbook becomes a portfolio for continued improvement in future years.
- A simplified "Systems Analysis" approach to an age old problem.



A NEW APPOINTMENT SCHEDULE FOR YOU!

Practice Productivity Inc. **Management Consultants to Physicians**

Please send:

_____ copies of Personnel Policies and Procedures For the Medical Office at $24.50 + $1.80 for shipping and handling:Total $26.30.

_____ copies of Appointment Scheduling That Works! at $14.95 + $1.60 for shipping and handling: Total $16.55.

Send to:

Name _____ Telephone ( ) _____

Practice Name _____ Specialty _____

Address _____ No. of Doctors _____

City _____ State _____ Zip _____ No. of Employees _____

Bank Americard or Master Charge No. _____ Expiration Date ____/____Signature _____

Allow 2 - 3 weeks for delivery. Make check payable and send to:

PRACTICE PRODUCTIVITY INC., 2000 Clearview Avenue, Atlanta, Georgia 30340 (404) 455-7344

Clinical experience & continuing confidence

KAON® ELIXIR was introduced in **1954,** followed by KAON® TABLETS in **1963.** Decades of clinical experience indicate acceptability, effectiveness, and safety in the majority of patients; should abdominal pain occur, therapy should be discontinued. Both have been taken by patient after patient, day after day, year after year, to correct potassium deficiencies. Both have consistently demonstrated their value when diet alone is inadequate for potassium replacement.

Kaon® Elixir
(potassium gluconate)

Kaon® Tabs
(potassium gluconate)

BRIEF SUMMARY
Kaon Tablets/Kaon Elixir

KAON® (potassium gluconate) TABLETS

Description: Each sugar-coated tablet supplies 5 mEq. of elemental potassium (as potassium gluconate 1.17 Gm.). Kaon Tablets are sugar coated, not enteric coated, which favors dissolution in the stomach and absorption before reaching the small intestine where the lesions with enteric potassium chloride have occurred. The sugar coating merely adds to palatability and ease of swallowing, not to delay absorption as does the enteric coating.
Indications: Oral potassium therapy for the prevention and treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. It may be used in the treatment of cardiac arrhythmias due to digitalis intoxication.
Contraindications: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause.
Warning: There have been several reports, published and unpublished, concerning nonspecific small-bowel lesions consisting of stenosis, with or without ulceration, associated with the administration of enteric-coated potassium tablets alone or when they are used with nonenteric-coated thiazides or certain other oral diuretics. These small-bowel lesions have caused obstruction, hemorrhage and perforation. Surgery was frequently required and deaths have occurred. Available information tends to implicate enteric-coated potassium salts, although lesions of this type also occur spontaneously. Therefore, coated potassium-containing formulations should be administered only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Coated potassium tablets should be used only when adequate dietary supplementation is not practical.
Precautions: In response to a rise in the concentration of body potassium, renal excretion of the ion is increased. With normal kidney function, it is difficult, therefore, to produce potassium intoxication by oral administration. However, potassium supplements must be administered with caution, since the amount of the deficiency or daily dosage is not accurately known. Frequent checks of the clinical status of the patient, and periodic ECG and/or serum potassium levels should be made. High serum concentra-

Time is the test of all things

1954
1978



tions of potassium ion may cause death through cardiac depression, arrhythmias or arrest. This drug should be used with caution in the presence of cardiac disease.

In hypokalemic states, especially in patients on a salt-free diet, hypochloremic alkalosis is a possibility that may require chloride as well as potassium supplementation. In these circumstances, Kaon (potassium gluconate) should be supplemented with chloride. Ammonium chloride is an excellent source of chloride ion (18.7 mEq. per Gram), but it should not be used in patients with hepatic cirrhosis where ammonium salts are contraindicated. Other sources for chloride are sodium chloride and Diluted Hydrochloric Acid, U.S.P.

It should also be kept in mind that ammonium cycle cation exchange resin, sometimes used to treat hyperkalemia, should not be administered to patients with hepatic cirrhosis.

Adverse Reactions: Nausea, vomiting, diarrhea and abdominal discomfort have been reported. The symptoms and signs of potassium intoxication include paresthesias of the extremities, flaccid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, fall in blood pressure, cardiac arrhythmias and heart block. Hyperkalemia may exhibit the following electrocardiographic abnormalities: disappearance of the P wave, widening and slurring of QRS complex, changes of the S-T segment, tall peaked T waves, etc.

Overdosage: Potassium intoxication may result from overdosage of potassium or from therapeutic dosage in conditions stated under "Contraindications." Hyperkalemia, when detected, must be treated immediately because lethal levels can be reached in a few hours.

KAON® (potassium gluconate) ELIXIR

Description: Each 15 ml. (tablespoonful) supplies 20 mEq. of elemental potassium (as potassium gluconate, 4.68 Gm.) with saccharin and aromatics. Alcohol 5%.

Indications: See Kaon Tablets.

Precautions: See Kaon Tablets.

In hypochloremic alkalosis, potassium replacement with potassium chloride (e.g., Kaochlor® 10% Liquid) may be more advantageous than with other potassium salts.

Adverse Reactions: See Kaon Tablets.

Overdosage: See Kaon Tablets.

WARREN-TEED
LABORATORIES, INC.
DIVISION OF **ADRIA LABORATORIES INC.**
COLUMBUS, OHIO 43215

When **impotence** *due to*

androgenic deficiency is driving them apart



Android®-5 Buccal Tabs

Android®-10 Oral Tabs

Android®-25 Oral Tabs

Methyltestosterone U.S.P. – 5, 10, 25 mg.

Additional Indications:

REPLACEMENT THERAPY. When Androgen Deficiency is cause of:

- Male Climacteric
- Eunuchoidism, Eunuchism
- Post-Puberal Cryptorchidism

New Double-Blind Study ANDROID-25 vs. Placebo*

*R. B. Greenblatt, M.D.; R. Witherington, M.D.,; I. B. Sipahioglu, M.D.; Hormones for Improved Sexuality in the Male and Female Climacteric. **Drug Therapy,** Sept. 1976.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE: Robert B. Greenblatt, M.D.,** and **D. H. Perez, M.D.:** "The Menopausal Syndrome," *Problems of Libido in the Elderly,* pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

BROWN **THE BROWN PHARMACEUTICAL CO., INC.** 2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

The Need for Laboratory Improvement in Ohio

John H. Ackerman, M.D., M.P.H.
Charles C. Croft, Sc.D.

Editor's Note: This article and the one following by Doctor Hawk present two sides to the question concerning regulation of clinical laboratories. The article by Doctors Ackerman and Croft supports the concept of legislative controls of clinical laboratories, while Dr. Hawk proposes extension of the current voluntary plan.— *R.L.M.*

TODAY, PHYSICIANS PLACE great reliance upon clinical laboratory results. Batteries of tests often are a part of the normal laboratory studies of patients, and they are becoming even more extensive as physicians seek to protect themselves against possible lawsuits. Accurate laboratory results can be a factor in the difference between health, productive life, or extended convalescence, or even death.[1] Can every physician rely on the results from his laboratory?

The Ohio Department of Health (ODH) has been involved in efforts of laboratory improvement for many years, much of which has been performed voluntarily by participating laboratories. Ohio has no overall legal regulations for clinical laboratories, despite various attempts at legislation dating back to 1961. Laboratories are approved to perform premarital and prenatal tests.

Licensing activities began in other states in 1938, when California passed a law regulating laboratories. Since then, 24 other states or possessions have legislated requirements, not all of which are comprehensive.

Federal control of laboratories begin in 1965 with the development of the Medicare Program. This was followed by the Clinical Laboratories Improvement Act in 1967, covering laboratories engaged in interstate commerce.

The Clinical Laboratory Improvement Act of 1977, currently being considered in Washington, would apply to all clinical laboratories in the United States. In Ohio, a bill to register clinical laboratories, blood banks, and tissue banks was introduced in 1975. It would have provided data concerning laboratories in Ohio as a basis for regulatory legislation in the future, however, hearings were not conducted on this bill. The bill being considered in the Congress would enable the State of Ohio to assume primary enforcement responsibility and to conduct its own program; this would require state legislation. For the time being, a large segment of laboratory activity in Ohio is under no licensure.

In 1967, the American Public Health Association called for measures to improve laboratory services, including licensure of laboratories, certification of professional personnel, training, proficiency testing, consultation, and adequately trained supervisory personnel.[2]

Ongoing examination of laboratory records by the Ohio Department of Health Laboratory has highlighted some of the problems of the lack of laboratory control. In all too many cases, physicians may not be aware of the quality of laboratory work; they may be assuming that if a laboratory performs a particular test, it does so with some degree of competence. Some examples are:

1. A hospital laboratory failed in its syphilis serology proficiency tests for the year. A consultant from our Department visited the laboratory to offer assistance. The laboratory director welcomed him, but asked if he could return at a later date because the girl who performed VDRL tests was on vacation and the person taking her place really didn't know that much about the test.

2. The laboratory at a large hospital participated in enteric bacteriology proficiency tests. Three samples were submitted, each of a different organism. The results of samples submitted showed identifications of organism #1 in the first specimen; organisms #1 and #2 in the second and organisms #1, #2, and #3 in the third specimen. These results show cross contamination from one sample to the next — an indication of poor technique.

3. A hospital laboratory participating in blood grouping and typing proficiency tests reported four incorrect ABO groupings and two incorrect Rh types.

A senior medical student who studied these matters concluded: "The proficiency and quality of (some of) the laboratories in our state is simply inadequate, and something must be done to change this."

Federal laboratory control programs (Medicare licensure and interstate laboratory licensure) require participation in ongoing proficiency tests. These tests are available from professional organizations and from the ODH program. During 1977, Ohio laboratories subscribed to the proficiency testing programs listed in Table 1.

In the ODH Program, compendiums of results are

Dr. Ackerman, Columbus, Director, Ohio Department of Health; and Assistant Clinical Professor of Preventive Medicine, The Ohio State University College of Medicine.
Dr. Croft, Columbus, Chief, Division of Public Health Laboratories, Ohio Department of Health.
Submitted December 20, 1977.

returning to participating laboratories, along with an analysis pointing out difficulties encountered and suggestions for improvement. Table 2 presents a summary of satisfactory and unsatisfactory reports for selected categories.

Another facet of the ODH Laboratory Improvement Program is the offering of bench training workshops in various specialized subjects for personnel from clinical and public health laboratories in Ohio, according to limitations of funds and personnel. Often, instructors from the National Center for Disease Control (CDC) are made available for this training. Examples of some of these workshops (excluding sanitary microbiology and alcohol test and approval) are as follows:

1971 — Training in enteric bacteriology and parasitology — four workshops, 62 students.

1972 — Darkfield microscopy, syphilis serology, gonorrhea cultures, rubella serology, antibiotic sensitivity testing, and enteric bacteriology were studied by 104 students in nine workshops.

1973 — Mycology, gonorrhea culture, antibiotic sensitivity, blood cell morphology, enteric bacteriology, darkfield microscopy, special medical bacteriology, laboratory management, and hepatitis B antigen were studied by 190 students in 12 workshops.

1974 — Mycoplasma, darkfield microscopy, gonorrhea culture, and rubella serology — nine workshops, 129 students.

1975 — Mycology, anaerobic bacteriology, enteric bacteriology, quality control in clinical chemistry, blood cell morphology, and parasitology were studied by 102 students in six workshops.

1976 — Training in covering blood cell morphology and enteric bacteriology — six workshops, 102 students.

In addition to the external quality control provided by proficiency testing, all laboratories should emphasize internal quality control and preventive maintenance. These are required of federally licensed laboratories.

Another problem for diagnostic laboratories concerns the availability and reactivity of in vitro diagnostic

TABLE 2. Results of Laboratories Tested in Selected Categories in Ohio Department of Health Proficiency Program

Subject	Year	No. of Labs.	Satisfact. %	Unsatisfact. %
Mycology	1971	145	87	13
	1972	161	40	60
	1973	150	37	63
	1974	166	56	44
	1975	156	60	40
	1976	152	54	46
Parasitology	1971	201	83	17
	1972	215	90	10
	1973	219	90	10
	1974	227	81	19
	1975	233	82	18
	1976	247	76	24
General bacteriology	1971	217	68	32
	1972	229	92	8
	1973	236	82	18
	1974	260	67	33
	1975	262	71	29
	1976	285	71	29
Enteric bacteriology	1971	215	88	12
	1972	213	86	14
	1973	231	89	11
	1974	243	95	5
	1975	262	91	9
	1976	257	91	9
Hemoglobin	1971 – I	297	86	14
	– II	286	74	26
	1972 – I	309	86	14
	– II	311	82	18
	1973 – I	322	83	17
	– II	319	80	20
	*1974 – I	329	97	3
	– II	334	89	11
	1975 – I	334	95	5
	– II	350	95	5
	1976 – I	359	93	7
	– II	360	90	10

*Different grading system initiated

Table 1. Proficiency Testing Programs Subscribed to by Ohio Laboratories in 1977

Program	No. of Ohio Laboratories
College of American Pathologists (various categories)	260
American Association of Bioanalysts	10
Center for Disease Control (interstate laboratories)	38
Ohio Dept. of Health (ODH) by category	
Syphilis serology	345
Clinical chemistry I	345
Clinical chemistry II	358
Blood group and type I	302
Blood group and type II	302
Hemoglobin I	334
Hemoglobin II	380
Bacteriology, general	268
Bacteriology, mycobacteria	198
Bacteriology, enteric	259
Bacteriology, gonorrhea	276
Mycology	137
Parasitology	240
Differential blood count	372
Irregular antibodies	186
Infectious mononucleosis	279
Urinalysis	322

products, many of which have been found to be unsatisfactory in the past.[3] The Food and Drug Administration controls in vitro diagnostics, and the program is being strengthened. Laboratories should specify to suppliers that they desire products which have been monitored by the testing program of the CDC. These also should be carefully checked at the time of use.

Discussion and Conclusions

Physicians should ascertain if the clinical laboratory serving them participates in an on-going proficiency testing program, and whether any difficulties have been indicated. Similarly, information should be available concerning internal quality control for all types of analyses for the verification and assessment of accuracy, measurement of precision, and detection of error.[4] Charts for clinical chemistry or hemoglobin determinations should be displayed indicating daily control limits and actions taken when results are outside acceptable limits.

Ohio should have a licensure law to include laboratories not now required to participate in any improvement program and to prevent unqualified laboratories from entering the state. Such a law would enable Ohio to control its own laboratories in the event of further comprehensive federal requirements.

References

1. *A Report on Laboratory Performance and Methods for Improvement.* US Department of Health, Education and Welfare, National Communicable Disease Center, June 1967.
2. *Policy Statement for Improvement of Laboratory Services.* Governing Council, American Public Health Association, Oct. 25, 1967.
3. *Public Hazards from Unsatisfactory Medical Diagnostic Products.* Report to the Congress by the Comptroller General of the United States, April 30, 1975.
4. Conditions for Coverage of Services of Independent Laboratories. *Federal Register,* title 20, chapt III, pt 405, subpt M, **39**:33690-33696 (Sept 19) 1974.



The Inspection and Accreditation Program of the College of American Pathologists

William A. Hawk, M.D.

Editor's Note: This article and the one preceding by Doctors Ackerman and Croft present two sides of the question concerning regulation of clinical laboratories. The article by Doctors Ackerman and Croft supports the concept of legislative controls of clinical laboratories, while Dr. Hawk proposes extension of the current voluntary plan.— *R.L.M.*

THE CLINICAL LABORATORY, whether independently operated or hospital based, has been and is being impuned almost daily by the news media and in the halls of Congress and the state legislatures. Allegations of fraud and incompetence have been made and, in a few instances, substantiated with resultant judicial remedy. Even though a majority of hospital and independent laboratories perform competent laboratory testing at a fair market price, an impressive array of federal departments, agencies, and bureaus have become involved in the regulation of the field of laboratory medicine. The U.S. Department of Health, Education, and Welfare, through the Center for Disease Control, the Bureau of Quality Assurance, the Bureau of Health Insurance, and the Food and Drug Administration, regulates a significant segment of laboratory medicine under the Clinical Laboratory Improvement Act of 1967 and other contracts granted by Congress. A number of states have enacted medical-laboratory licensure acts, and more are likely to follow suit. Collectively, the costs of these federal and state programs are considerable and represent an important increment in the rising total of health care costs.

The private sector of laboratory medicine perceived a need for laboratory improvement and, long before the advent of modern legislation, undertook a voluntary program designed to promote laboratory improvement through the College of American Pathologists. In November 1961, an Ad Hoc Committee on Accreditation of Laboratories reported to the Board of Governors of the College of American Pathologists. The report was accepted, and the accreditation program initiated with the initial policies regarding inspection and accreditation being established in February 1962. Standards to which all laboratories must adhere to remain accredited were established by the College of American Pathologists. Later, these standards were adopted by the Joint Commission on the Accreditation of Hospitals.

Dr. Hawk, Cleveland, Regional Commissioner, Great Lakes Region Inspection and Accreditation Commission, College of American Pathologists; and Chairman, Department of Pathology, The Cleveland Clinic.
Submitted August 12, 1977.

The United States was divided into ten geographic regions, and each region was placed under the charge of a regional commissioner appointed by the president of the College of American Pathologists. Each regional commissioner's laboratory was required to pass inspection and to be accredited by the Commission. The regional commissioner was impowered to select pathologists, members of the College of American Pathologists with accredited laboratories, to serve as inspectors in his region. This marked the beginning of the Inspection and Accreditation Commission of the College of American Pathologists (I and A Commission).

The value of the Inspection and Accreditation Program of the College of American Pathologists was appreciated by Congress, which provided for the program's inspection of laboratories engaged in interstate commerce under the conditions of the Clinical Laboratory Improvement Act of 1967. The program was recognized as equivalent to or more stringent than the requirements set forth in federal regulations. Under the provisions of the Act, a laboratory accredited by the College may apply for a letter of exemption from the Center for Disease Control, therefore achieving exemption to licensure for engaging in interstate commerce. The Center for Disease Control monitors the program by a reinspection of 10% of the laboratories so approved. In addition, equivalency meetings to assure that the program is in compliance with the law are held by officials of the Center for Disease Control and of the College of American Pathologists I and A Program.

The College is proud that the Inspection and Accreditation Program represents a fine example of peer review. The process is not an example of policing conducted with militancy, but rather an inspection conducted by a trained, qualified inspector who is a peer of the laboratory director. Most importantly, it is educational for the inspector and the laboratory director and his personnel. The College has no legal authority to close down laboratories upon denial of accreditation. However, virtually all laboratories which have voluntarily participated in the Program consider themselves better for their participation; and those laboratories initially denied accreditation, for the most part, have effected improvements such that accreditation could be awarded on subsequent inspections. The fact that over 1,500 laboratories have voluntarily participated in the program, with more joining each day, attests to its popularity.

Inspection Process

Upon receipt of an application for inspection, the

central office of the Inspection and Accreditation Commission sends the laboratory a series of application forms and checklists which are to be used in the laboratory's inspection. When checklists and application forms are received back at the central office, the regional or state commissioner in which the laboratory is located is requested to appoint an inspector. The College forwards all records regarding the laboratory to the inspector. If the laboratory is small, the inspector may do the entire inspection himself; he may form a team to inspect a large laboratory. Mutually, a date for the inspection is chosen.

The inspector presents himself to the laboratory and using the checklists, conducts an indepth inspection. Each section of the laboratory is carefully scrutinized. The quality-control programs are reviewed with emphasis placed on the results of controls for routine procedures, survey and proficiency testing results, instrument function checks, and temperature records where appropriate. Tolerance limits for procedures are evaluated, and the qualifications of the supervisory personnel are reviewed. The physical facilities, utilities, housekeeping, and the environment and safety regulations for the laboratory are inspected. Technical procedure manuals are investigated to ascertain if they are consonant with the laboratory procedures being performed currently and if there is evidence of annual review of these manuals. Reagents and standards are surveyed with particular reference to their quality and shelf life. Some checking system of volumetric glassware and measuring devices is required to be sure that they perform their function with accuracy. Instruments are scrutinized for function checks and instrument maintenance. The laboratory also is inspected for its emergency power sources, refuse disposal system, handling of toxic and contaminated wastes, monitoring of water supply, and glassware washing facilities. The inspector confers with the chief of the medical staff and the hospital administrator to learn their opinion of the laboratory services provided and the response of the laboratory to their needs.

The most important portion of the program, the post-inspection conference critique, concludes the inspection. During this conference, deficiencies noted are reviewed with the laboratory director and appropriate staff so that no misunderstandings occur. The inspector then submits his report to the central office of the College, where the findings of the inspection are computerized. Computer printout and the file are forwarded to the regional commissioner or to one of the regional commissioner's state commissioners for review, who forwards a copy of the computer printout with a covering letter to the laboratory. If deficiencies have been noted, the commissioner will require that those deficiencies designated as Phase II be corrected with documented proof of the corrective actions taken being sent to the College.

Deficiencies are categorized as being Phase I or Phase II. Phase I deficiencies are defined as minor and generally do not directly effect patient care. They should be corrected if possible. Phase II deficiencies are major deficiencies which must be corrected before accreditation can be granted. These deficiencies are regarded as having substantial effect on patient care. The laboratory is granted a period of 30 days to effect the corrective actions and to document them to the regional commissioner. On receipt of this material and upon satisfactory performance in the survey program, the regional commissioner recommends the laboratory for accreditation. Accreditation is granted by the I and A Commission and is valid for a period of two years.

For those laboratories engaged in interstate commerce and using the College inspection program in lieu of federal licensure, inspections are conducted on a yearly basis. Performances in survey are monitored on a quarterly basis by a special interstate commission. A special report is sent to each interstate laboratory. If a loss of proficiency is noted in any area and the problems are not corrected and the unacceptable results continue to be reported, the laboratory's approval to accept specimens for analysis in this area is restricted. Thus far, only eight laboratories have been temporarily restricted because of a deficiency.

Training Inspectors

The inspector is obviously a key person in the inspection and accreditation process. Criticism has been leveled concerning the stringency of one inspector compared to another. Much has been done to alleviate this criticism both in the computer-generated report and by an extensive seminar program designed to train inspectors. The computer-generated report brings out the same recommendations for correction of deficiencies for every laboratory. These recommendations are agreed upon by the members of the Inspection and Accreditation Commission in concert with the various resource committees of the College of American Pathologists. The I and A Commission has conducted an extensive series of seminars and 12 onsite inspector-training workshops in which the trainees conducted an inspection of a hospital laboratory under the tutelage of members of the Commission. To qualify as an inspector, a pathologist must have attended a laboratory-improvement seminar, had his own laboratory accredited, and usually be a member of the College of American Pathologists.

Program Revision

A special subcommittee of the Commission is continually at work revising the checklists. Ambiguous questions are clarified. As new methodologies and requirements or regulations are introduced, appropriate questions and commentary for the computer-generated report are prepared. The College has a series of resource committees assigned specific areas of laboratory medicine. These resource committees give input into the scientific validity and merit of many of the sections of the checklist; and when questions arise in the field, the resource committees may be called upon to give valuable counsel. The I and A Commission meets quarterly and discusses the current status of the checklist. The dynamic nature of the checklist can be attested to by the fact that in 1965, the checklist contained 40 pages with about 450 questions. Extensive revisions were completed on the checklist by 1973,

(continued on page 164)

INFECTION!
-a "dirty" word to surgeons...



...'ANCEF' helps "clean up" the site

'ANCEF' Offers Broad Coverage

of major areas of postsurgical infection due to susceptible indicated organisms (See Brief Summary below).

High, Prolonged Serum Levels Mean

most infections can be treated with 500 mg to 1 gram every 8 hours.

Cefazolin Levels in Tissues and Fluids*

'Ancef' is present in bone, synovial fluid, skin and soft tissues (such as pleural fluid and lymph nodes).

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

Indications: Ancef® (sterile cefazolin sodium, SK&F) is indicated in the treatment of the following serious infections due to susceptible organisms.

Respiratory tract infections due to *Streptococcus (Diplococcus) pneumoniae, Klebsiella* species, *Hemophilus influenzae, Staphylococcus aureus* (penicillin-sensitive and penicillin-resistant), and group A beta-hemolytic streptococci.

Injectable benzathine penicillin is considered to be the drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever.

'Ancef' is effective in the eradication of streptococci from the nasopharynx; however, data establishing the efficacy of 'Ancef' in the subsequent prevention of rheumatic fever are not available at present.

Genitourinary tract infections due to *Escherichia coli, Proteus mirabilis, Klebsiella* species, and some strains of enterobacter and enterococci.

Skin and soft-tissue infections due to *S. aureus* (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci and other strains of streptococci.

Bone and joint infections due to *S. aureus.*

Septicemia due to *Str. pneumoniae, S. aureus* (penicillin-sensitive and penicillin-resistant), *P. mirabilis, E. coli,* and *Klebsiella* species.

Endocarditis due to *S. aureus* (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci.

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to 'Ancef'.

Contraindications: 'Ancef' is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: BEFORE CEFAZOLIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS.

SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Antibiotics, including 'Ancef', should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Usage in Pregnancy—Safety of this product for use during pregnancy has not been established.

Usage in Infants—Safety for use in prematures and infants under one month of age has not been established.

Precautions: Prolonged use of 'Ancef' may result in the overgrowth of nonsusceptible organisms. Careful clinical observation of the patient is essential.

When 'Ancef' is administered to adults or children with low urinary output because of impaired renal function, lower daily dosage is required (see dosage instructions in the package literature).

A false-positive reaction for glucose in the urine may occur with Clinitest® tablets; use glucose enzyme-type reagents.

Adverse Reactions: The following reactions have been reported: Drug fever, skin rash, vulvar pruritus, eosinophilia, neutropenia, leukopenia, thrombocythemia, and positive direct and indirect Coombs tests have occurred. Transient rise in SGOT, SGPT, BUN, and alkaline phosphatase levels has been observed without clinical evidence of renal or hepatic impairment. Nausea, anorexia, vomiting, diarrhea, and oral candidiasis (oral thrush) have been reported. Pain at the site of injection after intramuscular administration has occurred, some with induration. Phlebitis at the site of injection has been noted. Other reactions have included genital and anal pruritus, genital moniliasis, and vaginitis.

Administration and Dosage: 'Ancef' may be administered intramuscularly or intravenously after reconstitution. See the package literature for reconstitution procedures.

See the package literature for dosage recommendations.

How Supplied: 'Ancef' (sterile cefazolin sodium, SK&F)—supplied in vials equivalent to 250 mg., 500 mg. or 1 gram of cefazolin; in "Piggyback" Vials for intravenous admixture equivalent to 500 mg. or 1 gram of cefazolin; and in Pharmacy Bulk Vials equivalent to 5 grams or 10 grams of cefazolin.

ANCEF® IV IM

brand of sterile

CEFAZOLIN SODIUM

(LYOPHILIZED)

Injection: 250 mg, 500 mg, and 1 gram vials

Smith Kline &French Laboratories
Philadelphia, Pa.

SK&F
a SmithKline company

*Tissue penetration is regarded as essential to therapeutic efficacy; however, specific tissue levels have not been correlated with specific therapeutic results.

(continued from page 161)

and it was increased to 80 pages with approximately 1,400 questions. The 1976 checklist contains over 1,800 questions. New areas are being added each year. Recently, questions were added for cytogenetics, laboratory computers, virology, and electron microscopy.

The Survey Program of the College of American Pathologists has evolved into an extensive program of surveys with over 8,200 subscribers; it is the largest in the world. This quality-evaluation program offers 22 different surveys. Laboratories desiring accreditation are required to participate in the basic proficiency testing survey as minimum. Surveys in chemistry, hematology, microbiology, and blood banking are encouraged; and special surveys are available in bacteriology, mycology, parasitology, mycobacteriology, diagnostic immunology, syphilis serology, toxicology, ligand assay, as well as instrumentation, advanced ligand assay, HBSg antigen, and nuclear medicine. A special survey committee of the College of American Pathologists is in charge of the program. Samples and a computerized tabulation of the results are sent out on a monthly basis. A special subcommittee of the Survey Committee of the College determines what results are acceptable and unacceptable. A laboratory is urged to indicate the corrective action taken concerning unacceptable results and inspectors look for documented evidence that such has been done. The Veterans Administration and the United States Air Force have contracted with the College of American Pathologists to provide proficiency testing services to their laboratories through this program.

Ohio Laboratories

There are 49 laboratories accredited by the Inspection and Accreditation Commission in the State of Ohio. The average cost for a survey of the laboratory of a 200-bed hospital is $995. For this fee, the participating laboratory processes a series of unknown specimens submitted by the College of American Pathologists. The College evaluates the laboratory's performance in comparison to a peer group, selected peer referees, and/or accepted medical usefulness criteria. A computer evaluation report is generated which displays the laboratory's results in relation to the evaluation criteria and pinpoints the performance for each procedure. From this, the laboratory director can detect problem areas in his laboratory and can initiate appropriate corrective actions with the help of the College's manual on quality evaluations. The fact that 90 Ohio hospitals not accredited by the Inspection and Accreditation Commission participate in the basic survey, 94 subscribe to comprehensive chemistry, and 94 to comprehensive hematology speaks for the value of this program as a management tool. The College's survey program is accepted by more than 42 states to meet the proficiency testing requirements for Medicare and/or state laws.

Aside from participating in the quality evaluation program of the College, to be accredited, a laboratory must meet the standards for accreditation of medical laboratories. These standards are as follows:

(1) "The pathology and clinical laboratories shall have sufficient space, equipment, and facilities for the performance of the required volume of work with optimum accuracy, precision, efficiency, and safety."

(2) "A hospital department of pathology and clinical laboratory shall be directed by a physician who is qualified to assume professional, organizational, and administrative responsibility for the department. The director of an independent laboratory must be a physician with training and experience in pathology or a clinical scientist with adequate training and experience in clinical laboratory work to meet the requirements of a laboratory director under the Laboratory Improvement Act of 1967. Sufficient personnel with training and experience adequate to supervise and conduct the work of the clinical laboratory shall be provided."

(3) "Channels of communication within the laboratories as well as with all other closely affiliated sections and services of the hospital and the medical staff shall be appropriate for the size and complexity of the organization."

(4) The quality control of the laboratory shall be designed to insure the medical reliability of laboratory data.

(5) "All specimens removed at operation must clearly be identified and sent to the pathologist accompanied by the pertinent clinical information. The extent of the examination is to be determined by the pathologist."

(6) "Space, equipment, and personnel shall be provided for necropsy service adequate for the needs of the institution."

(7) "A blood transfusion service must be maintained and directed by a pathologist or a physician qualified in immunohematology and blood banking."

(8) "Reports of all clinical pathology examinations shall be made part of the patient's hospital record."

Quality of Program

For a voluntary inspection and accreditation program to flourish, it must be superior to all other inspection and accrediting processes of government and it must satisfy consumers that it is indeed superior. The American College of Pathologists I and A Program has met this challenge. The unswerving goal of the College program has been laboratory improvement, and the mechanism for achieving this goal has been peer review. Pathologist inspects pathologist, and the tenor of the inspection is one of professionalism. Federal and state inspecting agencies are forced to hire full-time inspectors who must be trained in the inspecting process; however, for budgetary and other reasons, these inspectors are not pathologists or laboratory directors who function in the everyday world of laboratory medicine. This does not imply that the federal or state inspectors are incompetent or unable to achieve their appointed goals, but it does mean that these programs cannot function in the arena of pathology peer review. The founders of the Inspection and Accreditation Commission in the College of American Pathologists stressed the peer-review concept because of its inherent component-education. The thrust of a College inspection is as equally directed at detecting a fault in a given laboratory as it is at aiding the laboratory director in determining the correction of that fault. Corrections achieved through education are generally better accepted than those produced by enforced compliance.

It may be debated that one pathologist inspecting another invites untoward leniency on the part of the inspector and, hence, reduces the effectiveness of the inspection process. Such is not the case, but even if it were true, the effect of such leniency is minimized by the structure of the program.

The voluntary nature of the inspection in the accreditation program of the College of American Pathologists appeals to many laboratory directors. If their laboratories are accredited, they are assured that the laboratory complies with the requirements of both federal and state agencies.

Recently, the Association of Pathology Chairmen unanimously adopted a resolution to support and actively participate in the I and A Program. This support came for four reasons: (1) recognition that the I and A Program was an important tool enabling them to better manage their integrated clinical and anatomic pathology laboratories; (2) recognition that the program provided an excellent teaching mechanism to educate pathology residents in proper laboratory management; (3) recognition that within the I and A Program there are elements of academic freedom as provision is made to ask questions, to consider and debate problems, and to experiment, with the ultimate goal improvement in clinical laboratory medicine; and (4) recognition that by participating in the accreditation program, the chairmen can work with pathologists in private practice toward the goals of laboratory improvement.

For government to match the Inspection and Accreditation Program of the College of American Pathologists in terms of personnel and resources would cost millions of dollars. This far exceeds the amounts budgeted for such activities. The I and A Program operates in the private sector and, with only a few full-time employees, is an all-volunteer program. The pathologist-inspectors donate their time and expertise. The charges for inspections are used only to defray costs of the computer activities, production of checklists, maintenance of the central office, and out-of-pocket expense of inspectors and members of the commission. This national program operates in 50 states on a total budget amounting to less than $360,000. Few federal or state programs can offer so much for so little.

Summary

There is evidence that many laboratories continue to improve. However, too much regulation creates unanticipated problems. There is a need to temper this by peer review, education, and supervision. Regulation by government alone tends to become fixed and unresponsive. On the other hand, the I and A Program is responsive because it is composed of pathologists who function on a day-to-day basis in the practice of laboratory medicine and who, through their participation in the program, are aware of the problems and shortcomings in clinical laboratory medicine.

The College is justly proud of this effort of the private sector to assure the public and the medical profession of the highest quality of laboratory medicine. The program is a dynamic one, capable of adapting to the newer methodologies, newly introduced regulations, and new requirements of the medical profession. As laboratory directors have come to know, this is a program in pursuit of excellence.

Acknowledgement: The following reviewed this manuscript: Lawrence J. McCormack, M.D., Chairman, Council on Quality Assurance, College of American Pathologists; Major General Joe M. Blumberg, U.S.A. (retired), Chairman, Inspection and Accreditation Commission, College of American Pathologists; and John K. Duckworth, M.D., Vice-Chairman, Inspection and Accreditation Commission, College of American Pathologists.

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

OHIO OFFICES:

CINCINNATI: Room 700, 3333 Vine Street, (513) 751-0657, L. A. Flaherty

CLEVELAND: Suite 106, 23360 Chagrin Boulevard, Beachwood 44122, (216) 464-9950

A. C. Spath, Jr., R. A. Zimmerman

COLUMBUS: 1989 West 5th Ave., (614) 486-3939, J. E. Hansel

TOLEDO: 1011 Sandusky St., Suite H, P.O. Box 331, Perrysburg 43551, (419) 874-8080, R. E. Stallter


Kefzol® I.M./I.V.
cefazolin sodium
Ampoules, equivalent to 500 mg., 1 Gm.,
and 10 Gm. of cefazolin
NDC 0002-7014-01
AMPOULE No. 7014
Lilly
KEFZOL
STERILE
CEFAZOLIN
SODIUM
Equivalent to
10 Gm.
Cefazolin
Protect from Light
PHARMACY
BULK PACKAGE
KEFZOL
SODIUM
500 mg.
KEFZOL
SODIUM
1 Gm.
Additional information available
to the profession on request.
Eli Lilly and Company
Indianapolis, Indiana 46206
700773

Management of Severe Attacks of Ulcerative Colitis

Sheldon C. Binder, M.D.
Bertram Katz, M.D.

In a severe attack of ulcerative colitis, physician and surgeon must cooperate in an aggressively optimal medical regimen for inducing remission. If their nonoperative effects are not effective promptly, they must resort to early surgical intervention before the patient sustains a life-threatening complication or becomes so metabolically depleted that surgery becomes a desperate effort to save the patient's life. If surgery becomes necessary, one-stage, total proctocolectomy is the procedure of choice.

IN MILD CASES OF ulcerative colitis, either during the initial attack or during relapse in chronic disease, the management of the patient should be conservative medical treatment. Dietary regulation, general supportive care, antispasmodic drugs, Azulfidine®, and corticosteroids usually are used with favorable results in inducing remission. Surgical intervention is recommended for chronic debility or physical retardation, proven or suspected carcinoma, local complications of stricture or rectovaginal fistula, severe perianal disease, systemic complications, or as prophylaxis against carcinoma in patients with disease of ten-years' or longer duration. In severe attacks of ulcerative colitis, the risks of mortality and severe morbidity rise precipitously. Then, physician and surgeon must cooperate closely in an effort to induce remission in the attack. If their efforts fail, they must resort to surgical intervention before the patient sustains a life-threatening complication or becomes so metabolically depleted that surgery becomes a desperate effort to save the patient's life.

There are several well-established criteria which render the patient at high risk of mortality or of requiring surgery during attacks of ulcerative colitis.[1] Prime among these is the severity of the attack. The short-term mortality risk of patients with severe attacks ranges from 8 percent to 40 percent. Total colonic involvement associated with a severe initial attack has a 50-percent risk of requiring surgical intervention and a 17-percent mortality risk. In long-term follow-up of patients on medical management, total colonic involvement confers a mortality risk of 2.7 percent per year on the patient for the rest of his life. Children and adolescents are especially likely to suffer severe attacks of this disease, either initially or during relapse, and are more likely to require surgery than are adults. However, they can withstand the ravages of the disease and the stresses of the surgery much better, and their risk of mortality is low. Patients over 60 years old are less able to survive the stresses of their disease and surgery. In initial attacks of colitis, such elderly patients have a 17-percent mortality risk. In follow-up on medical management, they run a 4.9-percent annual mortality risk. This increases to 11 percent with total colonic involvement and to 14 percent if they develop a severe attack during relapse.

Diagnosis and Management

The most universally accepted criteria to define a severe attack of ulcerative colitis are those of Truelove and Witts[2]:

1. Severe diarrhea (six or more motions a day);
2. Macroscopic blood in the stools;
3. Fever (meaning evening temperature greater than 99.5 F [37.5 C] or a temperature of 100 F [37.8 C] or more on at least two days out of four);
4. Tachycardia (mean pulse rate of more than 90 beats per minute);
5. Anemia (allowances being made for recent transfusion); and
6. Erythrocyte sedimentation rate much raised (30 mm or greater in one hour).

Patients who satisfy these criteria of a severe attack should be hospitalized and managed aggressively in a close, joint effort by both internist and surgeon. Frequent clinical examination by experienced physicians is essential. The patient is given nothing by mouth. Nasogastric

From the Division of Surgery, The Youngstown Hospital Association, Youngstown, Ohio, and Northeastern Ohio Universities College of Medicine, Rootstown, Ohio.
Dr. Binder, Youngstown, Chief of Surgery, The Youngstown Hospital Association; and Professor of Surgery, Northeastern Ohio Universities College of Medicine.
Dr. Katz, Youngstown, Attending Surgeon, The Youngstown Hospital Association.
Submitted May 17, 1977.

suction is instituted for any signs of ileus or radiologic evidence of toxic dilatation of the colon. Fluid, electrolyte, and serum albumin deficits are corrected; significant anemia is treated with blood transfusion. Prothrombin deficiency is corrected with parenteral vitamin K_1 oxide. Parenteral corticosteroids equivalent to 300 to 400 mg hydrocortisone, or adrenocorticotropic hormone, 40 to 80 units, are administered intravenously daily. Diagnosis, if not already established, is made from plain x-ray films of the abdomen and by proctosigmoidoscopy; barium enema is not performed because of the risks of colonic perforation and of induction of toxic megacolon.[3] Plain x-ray films of the abdomen usually are sufficient to determine the extent of colonic involvement. They are made at least daily for early detection of the development of toxic megacolon, which occurs in 9.5 percent to 20 percent of severe attacks of ulcerative colitis. Opiates and anticholinergic drugs are used sparingly — if at all — because of their known risk of precipitating toxic dilatation of the colon.[3] Leucocyte counts and differential white blood cell counts are performed daily. The possibility of surgical intervention is anticipated by starting the patient on antibiotic bowel preparation, by mouth or via nasogastric tube. Systemic antibiotics are reserved for septic complications or if surgical intervention is elected. With such optimal, aggressive, medical therapy, about 55 percent of the patients will sustain remission during any severe attack.[1] Contrary to the fears of many physicians, intensive corticosteroid therapy does not increase the risks of severe complications and mortality[2,4] although it may mask the signs of some of the septic complications.

Indications for Surgical Intervention

Generally accepted indications for urgent surgical intervention during a severe attack of ulcerative colitis are: proved or suspected perforation of the colon, toxic megacolon, rarely massive hemorrhage, and sudden deterioration of the patient under medical management. Of these, intraperitoneal perforation carries with it the ominous prognosis of a mortality rate of over 25 percent.[3] Because toxic megacolon carries with it a 25-percent risk of perforation, it in itself may be considered an indication for urgent operation. Any rapid deterioration of the patient's overall clinical condition must be accepted as an indication for immediate surgical intervention since this is frequently the first sign of an otherwise occult perforation, a diagnosis made preoperatively or before death in only 50 percent of the cases in which it occurs.[5-7]

If the patient does not demonstrate dramatic, progressive improvement within a few days of initiation of optimal medical management, urgent surgical intervention should be performed. Goligher et al[8] and Watts et al[9] were able to reduce their overall mortality rate from 11.3 percent when there was a 12-to-17-day delay to 3.7 percent, their rate of colonic perforation from 32.5 percent to 11.1 percent, operative mortality from 20 percent to 7 percent, and the corresponding medical mortality from 4.8 percent to 0.7 percent. They effected these reductions by operating on all patients with severe attacks of ulcerative colitis that did not sustain remission within a five-to-seven-day course of intensive medical therapy. Their remission rate with the policy of earlier surgical intervention was not significantly lower than wth the more prolonged course of medical therapy. Those patients who were likely to sustain remission of their severe attack of ulcerative colitis were not, in their experience, deprived of the opportunity to do so because surgery was performed earlier. Furthermore, they discovered that 37.1 percent of the patients who survived without an operation during a severe attack of colitis subsequently required an operation; and an additional 3.6 percent of them died of their disease. These advantages of early surgical intervention have been well documented by other investigators.[4] The policy of early operation has proved to be the most significant factor in the dramatic reduction in early postoperative mortality associated with the surgery for ulcerative colitis since the early 1950s.

When elective surgery therapy is undertaken for patients with chronic ulcerative colitis, one-stage, total proctocolectomy is accepted by most surgeons as the operation of choice. In patients who require emergency or urgent operations, however, the frequently severe metabolic deterioration and the critical condition of the patients have induced many surgeons to perform less radical operations. Ileostomy alone as the primary operation, followed later by colectomy, has long since proved to be a totally inadequate operation with a prohibitive mortality rate. This is because the operation does not eliminate the patient's basic problem of a grossly diseased colon usually completely involved with ulcerative colitis and virtually certain to cause serious troubles in the future. Goligher et al[1] reported an early operative mortality of 19.5 percent in a review of 867 patients treated by primary ileostomy between 1948 and 1966; and Truelove et al,[10] as recently as 1965, reported an operative mortality of 16.1 percent. Turnbull et al[11] have advocated ileostomy and multiple "blow-hole" colostomies as a more conservative surgical approach, especially in patients with toxic megacolon; but we have achieved better overall results with the more definitive operation of emergency colectomy.[3] In a review of 2,071 primary colectomies or proctocolectomies for ulcerative colitis between 1952 and 1967, Goligher et al reported an overall mortality rate of 7.9 percent, 3 percent to 4 percent after elective operations and 10 percent to 20 percent after emergency surgery. Currently, most surgeons favor colectomy or proctocolectomy as the procedure of choice for emergency or urgent operations in cases of severe attacks of ulcerative colitis not responding to medical therapy or for acute complications of the disease.

For the critically ill patient requiring emergency surgery for severe ulcerative colitis and its complications, many surgeons advocate ileostomy and subtotal colectomy, leaving the rectum in place, to relieve the toxicity of the disease most expeditiously. This approach reduces operative time, blood loss, and the surgical trauma that proctectomy adds to colectomy; and, theoretically, it should reduce the risk of sexual impotence in the male patient.

The operation may inactivate the disease in the rectum and allow later restoration of intestinal continuity by ileorectal anastomosis. In theory, subtotal colectomy should carry with it a lower mortality and morbidity than emergency or urgent, one-stage, total proctocolectomy. In our series of 80 consecutive emergency and urgent colectomies for ulcerative colitis, with an overall mortality of 7.5 percent, the mortality after one-stage, total proctocolectomy (9.1 percent) was not significantly different from that after subtotal colectomy (7.0 percent).[4] Postoperative morbidity after proctocolectomy (mean postoperative hospitalization 27.6 days, nonseptic complication rate 29.4 percent, and septic complication rate 29.4 percent) was not significantly different from that following subtotal colectomy (mean postoperative hospitalization 33.3 days, nonseptic complication rate 45.0 percent, and septic complication rate 35.0 percent) in a group of patients with comparably severe attacks of colitis. Most surgeons have found that the nonfunctioning rectum retained after subtotal colectomy undergoes the same exacerbations and remissions of the disease as did the functioning rectum. Septic complications, hemorrhage, perforation, and carcinoma may occur in the colorectal remnant unless it is removed at a subsequent operation. The rectal changes seldom regress to the point that subsequent ileorectal anastomosis becomes a practical consideration. In our series, 75.7 percent of patients required subsequent abdominoperineal resection of the rectal segment, an operation which has substantial morbidity.[4] Therefore, most patients who survive subtotal colectomy must face the mortality and morbidity and the psychic trauma of a subsequent resection of the rectum, frequently when they are just beginning to experience the benefits of their initial colectomy. Because of injury to autonomic nerves in the pelvis during the abdominoperineal resection phase of the operation, postoperative sexual impotence is experienced in up to 15 percent of male patients undergoing proctocolectomy.[1] Any supposed protection to these nerves afforded by leaving the rectum in situ will be lost, however, if subsequent rectal excision is necessary, in which case consolidation of perirectal fibrosis may make the risk of operative injury even greater than with one-stage proctocolectomy. Aylett,[12] who reported a 95-percent success rate for colectomy and ileorectal anastomosis, did not report on the incidence of impotence; but his specific advice to interrupt the sympathetic nerves accompanying the inferior mesenteric vessels might in itself be expected to interfere with the ejaculatory mechanism. Most American investigators have reserved ileoproctostomy for the less than 10 percent of patients with quiescent, minimal, or no rectal involvement. Even then, the failure rate has been from 15 percent to 52 percent, and the incidence of subsequent rectal cancer has been as high as 6 percent.[13] Therefore, for the surgeon experienced in the surgical procedure of rectal resection, it proves more practical to resect the rectum in patients with severe attacks of ulcerative colitis who have substantial involvement of the rectum. One-stage, total proctocolectomy is the operation of choice.[4]

Summary

The patient suffering a severe attack of ulcerative colitis must have an aggressive course of optimal medical management in an attempt to induce remission. Any life-threatening complication of the disease must be managed by immediate surgical intervention. Since it is likely that a remission if it is to occur will do so within a few days after initiation of medical therapy, the physician should submit any patient for surgical operation who does not respond promptly. He should not persist in medical therapy to the point of sustaining complications or of rendering the patient so metabolically depleted as to substantially increase the risks of surgical intervention. Failing to achieve a prompt remission or faced with an acute complication of the severe attack of colitis, the surgeon should perform one-stage, total proctocolectomy as the operation of choice. Using the principles of earlier referral of patients for surgery, and of primary colectomy or proctocolectomy as the surgical procedure of choice, the physician and surgeon's cooperative approach to the severe attack of ulcerative colitis can achieve the respectable salvage rates reported by most investigators in recent years.

Generic and Trade Name of Drug

Sulfasalazine — Azulfidine (Pharmacia Laboratories)

References

1. Goligher JC, deDombal FT, Watts JM, et al: *Ulcerative Colitis,* Baltimore, Williams & Wilkins, 1968.
2. Truelove SC, Witts LJ: Cortisone in ulcerative colitis. *Br Med J* 2:1041-1048, 1955.
3. Binder SC, Patterson JF, Glotzer DJ: Toxic megacolon in ulcerative colitis. *Gastroenterology* 66:909-915, 1974.
4. Binder SC, Miller HH, Deterling RA Jr: Emergency and urgent operations for ulcerative colitis: the procedure of choice. *Arch Surg* 110:284-289, 1975.
5. Edwards FC, Truelove SC: The course and prognosis of ulcerative colitis. *Gut* 5:1-5, 1964.
6. Edwards FC, Truelove SC: The course and prognosis of ulcerative colitis. *Gut* 4:299-315, 1963.
7. deDombal FT, Watts JM, Watkinson G. et al: Intraperitoneal perforation of the colon in ulcerative colitis. *Proc R Soc Med* 58:713-715, 1965.
8. Goligher JC, Hoffman DC, deDombal FT: Surgical treatment of severe attacks of ulcerative colitis, with special reference to the advantages of early operation. *Br Med J* 4:703-706, 1970.
9. Watts JM, deDombal FT, Watkinson G, et al: Early course of ulcerative colitis. *Gut* 7:16-31, 1966.
10. Truelove SC, Ellis H, Webster CU: Place of a double-barrelled ileostomy in ulcerative colitis and Crohn's disease of the colon. *Br Med J* 1:150-153, 1965.
11. Turnbull RB Jr, Hawk WA, Weakley FL: Surgical treatment of toxic megacolon: ileostomy and colostomy to prepare patient for colectomy. *Am J Surg* 122:325-331, 1971.
12. Aylett SO: Three hundred cases of diffuse ulcerative colitis treated by total colectomy and ileo-rectal anastomosis. *Br Med J* 1:1001-1005, 1966.
13. Binder SC, Miller HH, Deterling RA Jr: Fate of the retained rectum after subtotal colectomy for inflammatory disease of the colon. *Am J Surg* 131:201-203, 1976.

The Selection of Candidates for Medical Education

Milton M. Parker, M.D., Ph.D.

DURING THE PAST 20 YEARS, a number of questions have been raised regarding the efficacy of the selection process of medical students. Such selection should carry on the tradition of excellently trained physicians who are motivated to provide the highest caliber of practical medical service while venturing into the unknown areas of medical science.

This concern actually originated much earlier as a result of the Flexner Report of 1910. However, it was overshadowed by the morass of poorly organized medical schools and curricula that was discovered. Therefore, the resulting effort was directed at the following: (1) weeding out "diploma mills," (2) prescribing minimum scholastic standards while evolving a program of self-improvement in faculty organization, (3) setting academic requirements for those who could teach as well as for students, (4) establishing core curricula, (5) providing equitable stipend for faculty, (6) acquiring suitable physical facilities for basic science and clinical instruction, and finally (7) establishing a candidate selection process based on academic aptitude.

Requirements

From 1910 to 1925, a very gradual evolution ensued during which most candidates with an above-average, collegiate academic record could find a place in a school of medicine. Not until about 1928 was there the requirement of a full, four-year, college education (or its equivalent), which had to include a baccalaureate degree. Simultaneously, emphasis was placed upon the course content of the baccalaureate study, which became known as the premedical curriculum.

Customarily, the premedical curriculum included biology (and later comparative anatomy), chemistry (general inorganic and organic and later qualitative analysis), physics, and mathematics. Courses in English, history, philosophy, psychology, sociology, the classics, and the *Bible* were regarded as of incidental interest.

Over the past four decades, evaluation emphasis has been placed upon the "cumulative point-hour ratio." However, even with the addition of the Medical College Aptitude Tests, efforts at making statistically valid distinctions have become progressively more difficult.

Dr. Parker, Columbus, Chairman, Department of Psychiatry, and Senior Attending Staff, Riverside Methodist Hospital; and Clinical Professor of Psychiatry, The Ohio State University College of Medicine.

Submitted July 11, 1977.

Candidate Selection

The rationalization for determining a statistical cut-off point for candidate selection cannot truly be denied: "We have a finite number of places available in each entering class, and we feel obligated to accept only the very best candidates." But it fails to deal with the fact that those of lesser point-hour status may be worth considering for reasons extraneous to the tubular vision directed at the point-hour ratio exclusively

For example, consider the problems posed by the recent influx of foreign medical graduates. These physicians represent an irregular array in quality of scientific preparation as well as language difficulties. Yet, when attempts have been made to restrict this influx, clamoring protests have arisen almost instantly. Most frequently, it is public hospitals and related institutions who insist that such restrictions will seriously hamper their ability to function. It appears that those we had so short-sightedly turned away as being below the statistical cut-off point could readily surpass the quality of such foreign physicians upon whom many institutions have become so dependent.

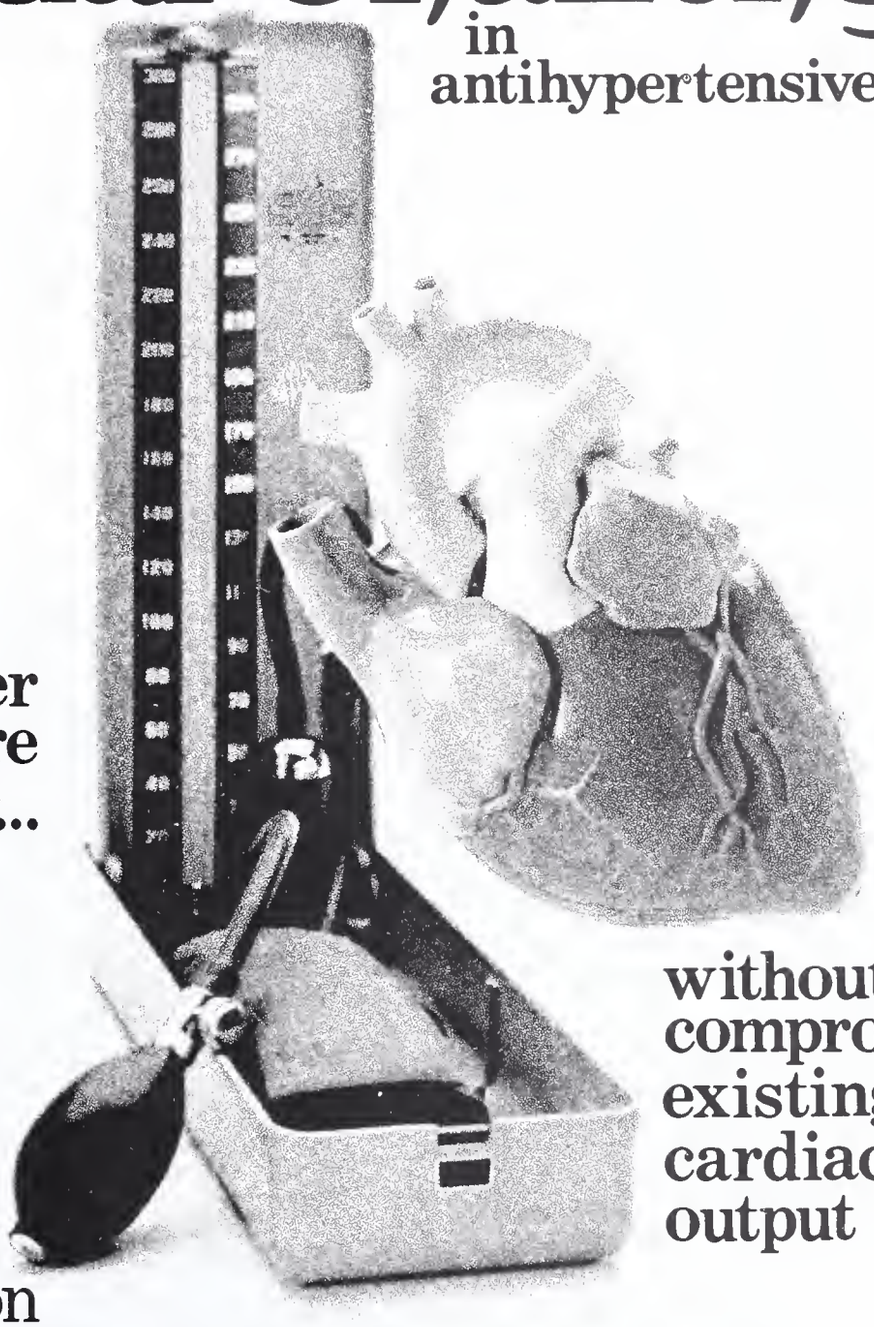
Recently, more individuals have entered physician training through appreciable increases in the enrollments of well-established medical schools and through enrollment in new institutions. Some of these new medical schools are located in states which previously had contained not even one school. Whether these changes will allow all truly qualified individuals to enroll remains to be seen. However, it seems unlikely that the United States will have a surplus of adequately trained, "home-grown" products, although grumblings to this effect already have been heard in some quarters.

In addition to the consideration as to whether a "statistical cut-off point" may eliminate otherwise qualified and/or desirable candidates, thought should be given to choosing students who can cope with increasing government intervention in medicine. Such recent intrusions as Medicare, Medicaid, and health planning agencies will have to be dealt with on a continuing basis. When nonmedical social planners plot a socio-political-economic course for American medicine, we must have those in our ranks who are equipped to contend with "the planners." They must represent us in a truly effective, constructive fashion.

How well have we, in fact, selected? Indeed, when may we expect to discard our parochial orientation in favor of observing the panorama which lies before us? Do we have physicians with the breadth of vision required to face the future of American medicine knowledgeably, boldly, and with the requisite sophistications?

A Dual Challenge

in antihypertensive therapy



to lower blood pressure effectively...

without compromising existing cardiac output

in hypertension

TABLETS: 250 mg, 500 mg, and 125 mg

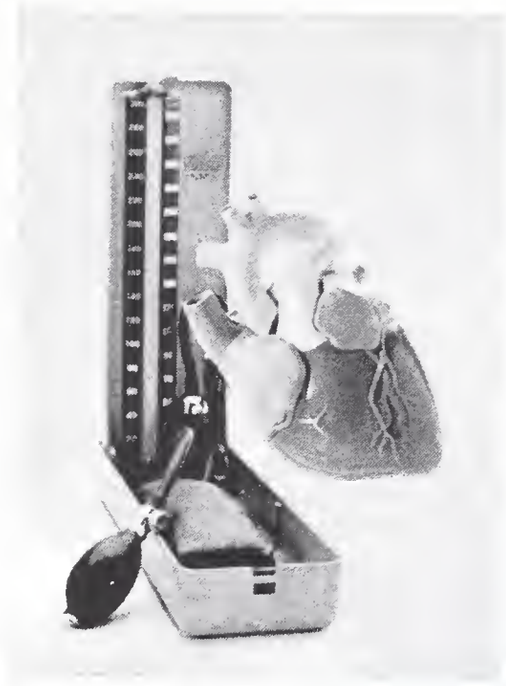
ALDOMET® (METHYLDOPA | MSD)

helps lower blood pressure effectively... usually with no direct effect on cardiac function–cardiac output is usually maintained

ALDOMET is contraindicated in active hepatic disease, hypersensitivity to the drug, and if previous methyldopa therapy has been associated with liver disorders.
It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

For a brief summary of prescribing information, please see following page.

MSD
MERCK SHARP & DOHME



in hypertension

ALDOMET®

(METHYLDOPA|MSD)

helps lower blood pressure effectively... usually with no direct effect on cardiac function– cardiac output is usually maintained

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis; if previous methyldopa therapy has been associated with liver disorders (see Warnings); hypersensitivity.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, occasionally with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reactions or unusual manifestations of drug idiosyncrasy.

Pregnancy and Nursing: Use of any drug in women who are or may become pregnant or intend to nurse requires that anticipated benefits be weighed against possible risks; possibility of fetal injury or injury to a nursing infant cannot be excluded. Methyldopa crosses the placental barrier, appears in cord blood, and appears in breast milk.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of: urinary uric acid by the phosphotungstate method, serum creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has recurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: *Central nervous system:* Sedation, headache, asthenia or weakness, usually early and transient; dizziness, lightheadedness, symptoms of cerebrovascular insufficiency, paresthesias, parkinsonism, Bell's palsy, decreased mental acuity, involuntary choreoathetotic movements; psychic disturbances, including nightmares and reversible mild psychoses or depression.

Cardiovascular: Bradycardia, aggravation of angina pectoris. Orthostatic hypotension (decrease daily dosage). Edema (and weight gain) usually relieved by use of a diuretic. (Discontinue methyldopa if edema progresses or signs of heart failure appear.)

Gastrointestinal: Nausea, vomiting, distention, constipation, flatus, diarrhea, mild dryness of mouth, sore or "black" tongue, pancreatitis, sialadenitis.

Hepatic: Abnormal liver function tests, jaundice, liver disorders.

Hematologic: Positive Coombs test, hemolytic anemia. Leukopenia, granulocytopenia, thrombocytopenia. Positive tests for antinuclear antibody, LE cells, and rheumatoid factor.

Allergic: Drug-related fever, lupus-like syndrome, myocarditis.

Other: Nasal stuffiness, rise in BUN, breast enlargement, gynecomastia, lactation, impotence, decreased libido, dermatologic reactions including eczema and lichenoid eruptions, mild arthralgia, myalgia.

Note: Initial adult dosage should be limited to 500 mg daily when given with antihypertensives other than thiazides. Tolerance may occur, usually between second and third months of therapy; increased dosage or adding a diuretic frequently restores effective control. Patients with impaired renal function may respond to smaller doses. Syncope in older patients may be related to increased sensitivity and advanced arteriosclerotic vascular disease; this may be avoided by lower doses.

How Supplied: Tablets, containing 125 mg methyldopa each, in bottles of 100; Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 500.

For more detailed information, consult your MSD representative or see full prescribing information.

Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

J6AM07R1(709)

MSD MERCK SHARP & DOHME

OHIO STATE Medical Association Cancer Education Series*

Management of the Cancer Patient in the Community Hospital

Neal J. Prendergast, M.D.
James C. Maher, M.D.

CANCER, the second leading cause of death in this country, commands significant public and political interest. In recent years, federally funded cancer centers, designed to deliver highly sophisticated care for cancer patients and to conduct meaningful productive research in cancer care and control, have been located strategically around the country. In Ohio, about 35,000 new cases are detected annually, but less than 15% of these patients can be cared for in cancer centers. Obviously, the overwhelming burden of cancer care falls upon local, primary care physicians and the community hospital. At least 85% of cancer patients will be treated locally at no sacrifice in quality of care if adequate programs are developed on the local level, in cooperation with national and regional research centers. The advantage of being near family and friends in a familiar and reassuring environment is of inestimable value to cancer patients at a critical point in their lives.

Oncology Program

The development of an effective cancer program in the community hospital requires the cooperation and dedication of the medical and nursing staff, hospital administration, laboratory personnel, physical therapy department, psychiatric social services, the clergy, and the local cancer society. The initial impetus for establishing such programs is provided by physicians trained in or interested in cancer therapy. Fortunately, there has been an increase in oncology training programs, and more physicians trained in cancer care are available to smaller communities. Assistance in establishing cancer programs in community hospitals is available through a variety of sources. The Ohio State University Comprehensive Cancer Center has sponsored several such programs and liaison with the cancer center provides readily available consultation, referral, and education programs. The recently established Association of Community Cancer Centers (ACCC) is available in an advisory capacity to communities interested in establishing and maintainng community programs. The American College of Surgeons provides consultation to hospitals for the establishment, maintenance, and accreditation of tumor registries.

The cornerstone of an effective hospital oncology program is the Tumor Committee. The Tumor Committee should be composed of a chairperson, preferably a trained medical or surgical oncologist, representatives from the departments of medicine, surgery, gynecology, urology, pathology, radiology, the nursing service, and advisory representation from ancillary services such as psychiatry, social service, and chaplain services. The primary function of the Tumor Committee is educational. It should keep the staff apprised of recent advances in cancer detection, treatment, and follow-up and assist in establishing protocols for cancer staging and standards of treatment. This Committee at our institution periodically conducts conferences covering all aspects of the common malignancies and reviews all new cancer cases monthly. Exceptions to standards of patient care are brought to the attention of the attending physician. Under the Committee's direction, at least two cancer care audits are conducted annually and compliance with standards of care and end results of treatment compared to national standards. The Committee also functions in a consultative capacity to the hospital medical staff and outside physicians; it does not attempt to remove the responsibility for making the final decision concerning patient care from the attending physician.

Ambulatory Patient Care

Ambulatory care for cancer patients is a vital function of the community hospital. The majority of cancer

Dr. Prendergast, Gallipolis, specializes in hematology-oncology, and is a Staff Member Holzer Medical Center Hospital.
Dr. Maher, Gallipolis, specializes in internal medicine, and is a Staff Member, Holzer Medical Center Hospital.
Submitted October 3, 1977.

*_The Journal_ is pleased to publish this series through the cooperation of the OSMA Committee on Cancer and the American Cancer Society, Ohio Division Inc.

patients, including those with advanced disease, can be treated in an outpatient setting with intensive chemotherapy. Outpatient management has definite economic and psychologic advantages as most third-party insurers will pay for outpatient therapy to avoid the increased costs of inpatient treatment. Multidrug treatment of malignant lymphomas, breast, ovarian, lung, and testicular carcinomas are well tolerated in the outpatient setting. The hospital laboratory is convenient to provide blood counts and serum chemistry studies promptly, and radiology services can make on-the-spot, follow-up roentgenograms. Members of the hospital nursing services can be readily trained to assist with the administration of intravenous chemotherapy. The ambulatory care cancer clinic can handle 20 to 30 patients a day, utilizing one physician, a nurse, and an aide. We have found that blood transfusions can be given conveniently in the clinic. Our hospital pharmacy provides chemotherapy drugs to our patients at wholesale cost.

The community hospital laboratory participating in an active oncology program must make certain adaptations. The blood bank should be prepared to provide blood-component-transfusion therapy to patients with a suppressed bone marrow. Red blood cells and platelets usually are readily available through the hospital blood bank or the American Red Cross although platelet availability often entails some delay and anticipation of need. Determination of tumor markers, such as carcinoembryonic antigen and chorionic gonadotrophin analysis, and the determination of estrogen receptor sites should be available. The microbiology division of the laboratory must be able to identify opportunistic pathogens which so often occur in immunosuppressed patients.

Limitations

Although the majority of cancer patients can be treated satisfactorily in the community hospital, there are limitations. Community hospitals may not have the facilities for radiation therapy; this is inconvenient for patients and physicians and results in fragmentation of care. Rare tumors and unusual complications with which the staff has little experience should be referred to large regional centers. Most pediatric malignancies should be cared for in pediatric oncology centers. Patients with malignancies requiring complex chemotherapy and intensive, sophisticated, supportive care, such as acute leukemia, should also be referred to special centers.



WINDSOR HOSPITAL
A NONPROFIT CORPORATION
— ESTABLISHED 1898 —
Chagrin Falls, Ohio
247 - 5300
A hospital for the treatment of Psychiatric Disorders
High on a Hill-Top, Overlooking Beautiful Chagrin River Valley.
Accredited by Joint Commission on Accreditation of Hospitals.
Booklet available on request.
FRIEDRICH A. LINGL, M.D. Medical Director
GUY H. WILLIAMS, JR., M.D. Medical Director Emeritus
HERBERT A. SIHLER Jr. President
MEMBER: American Hospital Association—National Association of Private Psychiatric Hospitals



Singalongs, German Band, Cocktails and Keg Beer. All meats, desserts, and soups are made right here in Schmidt's immaculate kitchens. Ask to see. Buy Bratwurst and Bahama Mamas to take home. 4 blocks East of S. High St. on Kossuth, just a few blocks from your medical association headquarters.
Fantastic new private party and meeting rooms serving German Buffet or any size sizzling Top Grade steak dinners. Reservations taken for parties 35 and up. Call 444-5050.
Liveliest Spot In German Village
Noon and Night

COMPLETE YOUR PROFESSIONAL LIABILITY INSURANCE PLAN

This special service is designed for physicians who are not able to obtain occurrence excess coverage from their primary insurer or who have a claims made excess policy that is subject to large surcharges.

If you are in either group and meet PICO's underwriting requirements, you can continue your present primary protection while adding PICO's excess coverage. Or, you can have both primary and excess coverage through PICO's superior, all-inclusive plan.

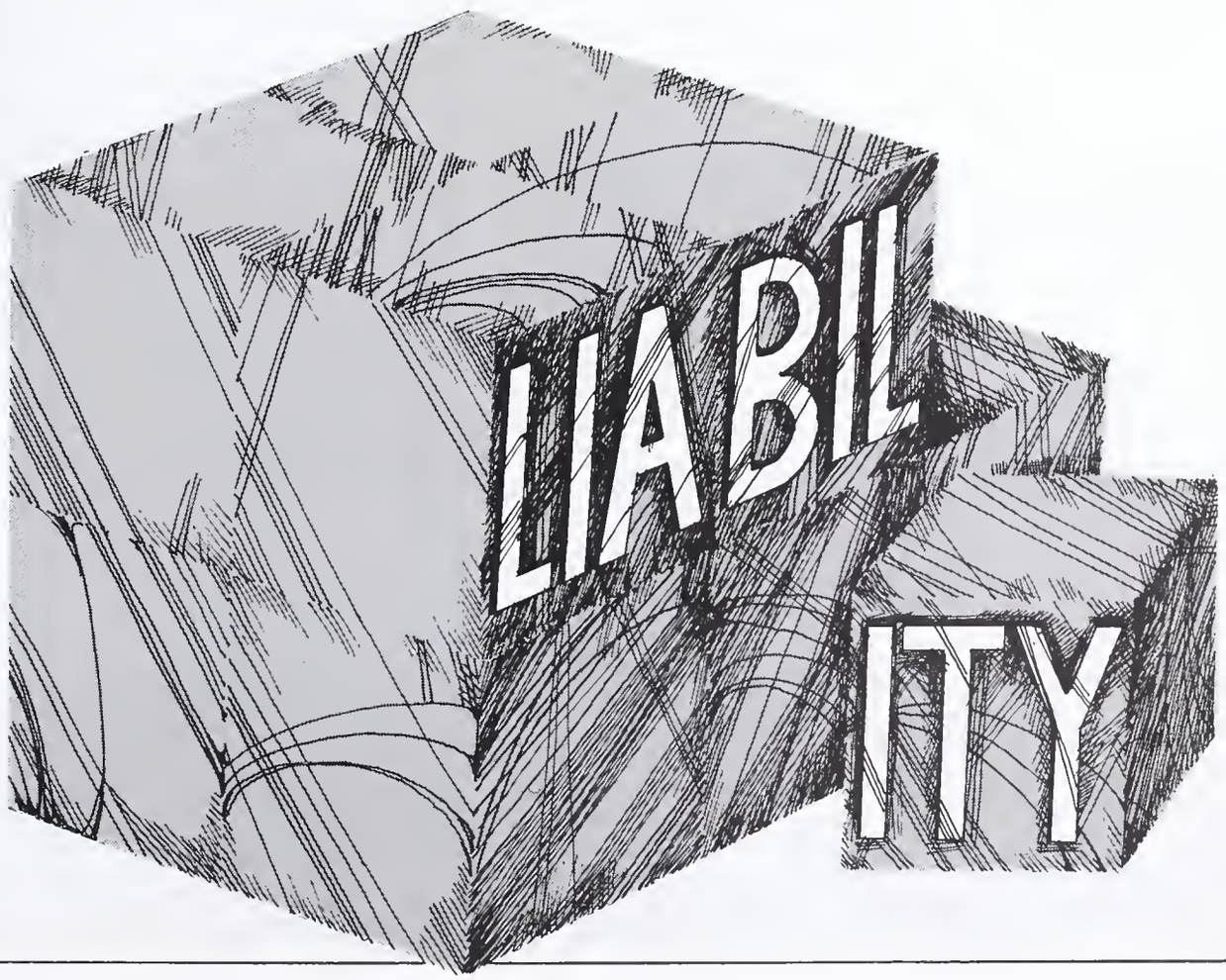
Either way, complete your protection with PICO.

PICO's $1 million occurrence excess coverage is now available to members of the O.S.M.A. who have primary coverage of $200,000/$600,000 with another approved medical insurer.

Physicians Insurance Company of Ohio

P.O. Box 27905
6100 Channingway Boulevard
Columbus, Ohio 43227

Telephone (Toll-Free) 1-800-282-7515 for the name of the authorized PICO representative in your area.



THE OHIO STATE Medical Association New Members

ALLEN
Richard R. Capone
Eduardo Gallo
Michael R. Heaphy
Christos B. Ioannidis
James L. Kahn
Ramanath Pai
S. R. Pai
John S. Sandy
C. W. Schweizer
R. L. Terry

BUTLER
Mariano M. Alvira, Cincinnati
Calvin E. Jones, Hamilton
Charles F. Margolis, Fairfield
Richard S. McVey, Hamilton
Stephen R. Pledger, Middletown
Greg L. Savage, Hamilton

CLERMONT (Batavia)
Sanat R. Bhatt

CLINTON (Wilmington)
John Hollon
Ting Wai Wang

COLUMBIANA (Lisbon)
Banarikammaje Bhat

COSHOCTON (Coshocton)
Leon Koen

DELAWARE (Delaware)
Linda B. Pantangco

FAYETTE
T. C. Hsieh, Washington C.H.
Wm. P. Zitter, Huntington, W. Va.

FULTON (Wauseon)
John E. Arville

GALLIA (Gallipolis)
James C. Maher, III
Charles A. Webb

GREENE (Xenia)
A. A. Garrafa
Rajendrabhai A. Patel

GUERNSEY (Cambridge)
David Mungcal

TREAT THE SYMPTOMS IN THE GERIATRIC PATIENT

APATHY • IRRITABILITY
FORGETFULNESS • CONFUSION



Cerebro-Nicin® CAPSULES

A GENTLE CEREBRAL STIMULANT & VASODILATOR FOR GERIATRIC PATIENTS

Each CEREBRO-NICIN capsule contains:
Pentylenetetrazole .....100 mg. • Nicotinic Acid ...100 mg.
Ascorbic Acid .....100 mg. • Thiamine HCl .....25 mg.
l-Glutamic Acid .....50 mg. • Niacinamide .....5 mg.
Riboflavin .....2 mg. • Pyridoxine HCl .....3 mg.
AVAILABLE: Bottles 100, 500, 1000
SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and abdominal cramps. The reaction is usually transient.
INDICATIONS: As a cerebral stimulant and vasodilator.
RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.
WARNING: Overdosage may cause muscle tremor and convulsions.
CONTRAINDICATIONS: Epilepsy or low convulsive threshold.
CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

Write for literature and samples . . .
BROWN THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057

HAMILTON (Cincinnati)
Felix R. Canestri
Robert L. Faul
Carl G. Fischer
Bruce Greenberg
Steven H. Grendel
Irving Igdaloff
Bill J. Karas
Stewart Krug
Kris Mahalingam
Donald L. Mitts
David S. Norris
Plutarco A. Santana
Victor R. Smith
Philip L. Zaacks

LAWRENCE (Wheelersburg)
Tei Yi Tsou

LORAIN (Amherst)
Piara Lai Arora

LUCAS (Toledo)
Francis J. Hahn

MADISON (London)
Sooja Kim

MONTGOMERY (Dayton unless noted)
John M. Bennett
Michael Ervin
Keith E. Girton, Vandalia
Charles D. Goodwin
Charles D. Joffe
Richard C. Juberg
Samuel Kramer
Richard H. Laib
Milton F. Nathan
Robert C. Prophater, Jr., Vandalia
James A. Ruehle
Rajagopalan Sivaprasad
Rasoul Soudmand
Gilbert W. Templeton

MUSKINGUM (Zanesville)
Surinder K. Bansal
John W. Steinberger
Gerald J. Tiberio

Vicki Ann Whitacre

PORTAGE (Kent)
Mohammed As-Sanie

SCIOTO (Portsmouth)
Kou Sin Liu
Jean F. Spiro

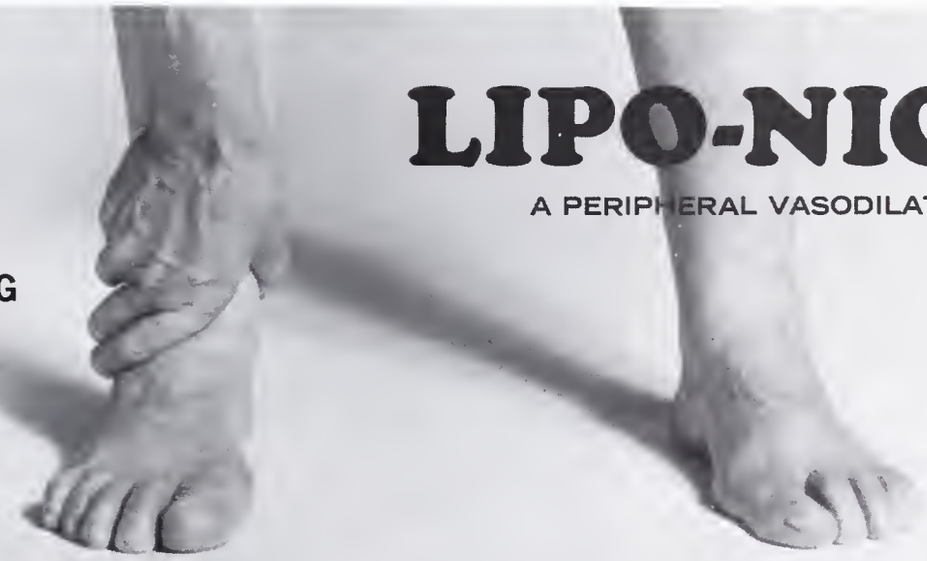
STARK (Canton)
Vlasios P. Albanis
Jay P. Berke
Allen J. Rovner

SUMMIT (Akron unless noted)
J. F. Alexander
Danilo Martinez
Douglas A. Regula

TRUMBULL (Warren)
Dong Mah
Joseph Tori

TUSCARAWAS (Dover)
Tomas R. Arejola
Umesh Betkerur

COLD FEET
LEG CRAMPS
TINNITUS
DISCOMFORT ON STANDING



LIPO-NICIN
A PERIPHERAL VASODILATOR

IMMEDIATE or GRADUAL
nicotinic acid therapy

IMMEDIATE RELEASE

LIPO-NICIN/100 mg.
Each blue tablet contains:
Nicotinic Acid .....100 mg.
Niacinamide ..... 75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .. 25 mg.
Riboflavin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6).. 10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500, 1000.

LIPO-NICIN/250 mg.
Each yellow tablet contains:
Nicotinic Acid .....250 mg.
Niacinamide ..... 75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .. 25 mg.
Riboflavin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6).. 10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500, 1000.

GRADUAL RELEASE

LIPO-NICIN/300 mg.
Each time-release capsule contains:
Nicotinic Acid .....300 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (H-1) .. 25 mg.
Riboflavin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6).. 10 mg.
In a special base of prolonged therapeutic effect.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient. Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur. Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

BROWN THE BROWN PHARMACEUTICAL CO., INC. 2500 West Sixth Street, Los Angeles, California 90057
Write for Literature and Samples
REFER TO PDR

THE OHIO STATE Medical Association News

OSMA President Wells Discusses Affect of Energy Shortage on Health Care

On Wednesday, February 15, the Ohio State Medical Association, in conjunction with the Ohio Hospital Association, held a press conference to discuss the serious effects that an extended electrical shortage could have on the delivery of health care in Ohio. OSMA President William M. Wells, M.D., spoke for the Association; and Mr. Ben Holland, Assistant Administrator, Grant Hospital, Columbus, represented the Hospital Association. The participants noted that physicians' offices are not exempt from blackouts nor are clinics. Hospitals are exempt; however, they are participating in voluntary cutbacks. The only other exemptions apply to patients on home life-support systems.

A related story involves this letter commending Ohio physicians for their participation during the January blizzard.

450 E. Town Street
Post Office Box 118
Columbus, Ohio 43216
Telephone (614) 466-3543
If no answer (614) 466-8686

JAMES A. RHODES
Governor

JOHN H. ACKERMAN, M.D., M.P.H.
Director of Health

February 13, 1978

William M. Wells, M.D., President
Ohio State Medical Association
600 South High Street
Columbus, Ohio 43215

Dear Dr. Wells:

I would like to extend my deep appreciation to the physicians of the State of Ohio for their magnificant performance during the recent blizzard.

Under the most severe conditions ever experienced, truly heroic deeds were performed in saving lives and continuing to provide medical care to our citizens.

We hear many criticisms of our medical care system today. It is in challenging circumstances that the true value of that system is shown.

Ohio can be truly thankful for its physicians and their devotion to providing services in time of need.

Sincerely,

John H. Ackerman, M.D.
Director of Health

JHA/jv

OSMA Policy Dividend Declared

The largest dividend ever declared for the OSMA Group Term Life Insurance Plan has been announced by Hart F. Page, C.A.E., OSMA Executive Director. The 50% dividend covers the policy year ending August 31, 1977. Such dividends have become commonplace for the plan, as records show that 47% was returned to members as a dividend in 1971, 23% in 1972, 43% in 1973, 29½% in 1974, and 44% in 1975. In 1976, even though the gross premium was reduced 10%, a dividend of 43% was paid.

Physician participation in the Group Term Life coverage is limited to OSMA members. The maximum amount of coverage available is $100,000, with eligibility restricted to those under age 70 years. To learn more about this advantage of OSMA membership, contact one of the Ohio offices of Turner and Shepard, Inc. located in Cincinnati, Cleveland, Columbus, and Toledo.

Suit Filed Against Blues of Michigan

The Michigan Psychiatric Society, two Michigan psychiatrists, and two psychiatric patients have filed suit in the Federal District Court in Detroit against Blue Cross and Blue Shield of Michigan over a recent cutback in outpatient psychiatric benefits. The plaintiffs allege that a recent cutback in outpatient psychiatric benefits in a Master Medical Plan arbitrarily discriminates against outpatient care as a mode of psychiatric treatment. They also allege that this action will have the effect of forcing patients receiving outpatient care to enter inpatient facilities and, consequently, will drive up health care costs. Under the Blues' Master Medical Plan at issue, annual and lifetime coverage maximums for physical illnesses and inpatient psychiatric care remain at $15,000 and $30,000 levels, but annual and lifetime maximums for outpatient care are reduced to $2,000 and $5,000 respectively.

Medical Facilities Begin Accepting American Express Card

American Express recently began notifying its cardmembers that the American Express Card will be accepted at more than 145 medical facilities throughout the United States and Canada. The hospitals and medical centers were specially selected to be near places where most people travel. According to Maurice Segall, President of the Card Division, this action was undertaken so that cardmembers "can receive outpatient or emergency medical attention without delay or red tape. . . ." One of the first hospitals was signed into the program when a vacationing French family needed medical attention but did not have the cash to pay for it. American Express expects to expand the service in the future.

This asthmatic isn't worried about his next breath...



he's active he's effectively maintained on

QUIBRON®

Each capsule or tablespoon (15 ml) elixir contains theophylline (anhydrous) 150 mg and glyceryl guaiacolate (guaifenesin) 90 mg. Elixir: alcohol 15%

- high theophylline for effective around-the-clock therapy
- 100% free theophylline
- individualized theophylline dosage schedule

Indications: For the symptomatic treatment of bronchospastic conditions such as bronchial asthma, asthmatic bronchitis, chronic bronchitis, and pulmonary emphysema.
Dosage: Initial: Adults: 1-2 capsules or 1-2 tablespoonfuls elixir every 6-8 hours, children 8-12: 1 tablespoonful or one capsule every 6-8 hours and children under 8: 3 to 5 mg theophylline/kg body weight every 6-8 hours. Theophylline dosage may be cautiously increased to 2000 mg/24 hr in adults or 7 mg/kg in children; monitoring of serum theophylline levels of higher dosages is recommended.
Precautions: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other xanthine derivatives concurrently. Use in case of pregnancy only when clearly needed.
Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea and vomiting. The frequency of adverse reactions is related to the serum theophylline level and are not usually a problem at serum theophylline levels below 20μg/ml.
How Supplied: Capsules in bottles of 100 and 1000 and unit-dose packs of 100; Elixir in bottles of 1 pint and 1 gallon.

Mead Johnson
PHARMACEUTICAL DIVISION

© 1978 Mead Johnson & Company • Evansville, Indiana 47721 U.S.A. MJL 6-4220R



Does it influence your choice of a peripheral/cerebral vasodilator*?

- Vasodilan—compatible with coexisting diseases
- Vasodilan—compatible with concomitant therapy
- Vasodilan—compatible with your total regimen for vascular insufficiency

*Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.
Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily.
Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

U.S. Pat. No. 3,056,836

VASODILAN®
(ISOXSUPRINE HCl)
20-mg tablets

Mead Johnson PHARMACEUTICAL DIVISION

© 1978 MEAD JOHNSON & COMPANY · EVANSVILLE, INDIANA 47721 U.S.A. MJL7-4268

The Ohio State Medical Association Continuing Education Programs

Editor's Note: *The following are Category I courses offered in Ohio. Items for this listing come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in dates, places, or time occur too late to be corrected before publication. Physicians interested in a course are urged to contact the sponsoring organization to confirm the information listed. Sponsoring organizations may list Category I courses by contacting the OSMA Department of Continuing Medical Education or The Journal. Notification 90 days prior to the course would be appreciated. Due to space limitations, announcements may be published only once.* **See previous issues of The Journal for additional courses.**—*L.A.J.*

COMMUNICATIONS/PUBLIC RELATIONS SEMINAR

March 8-9 Ohio University Inn, Athens
March 22-23 Sheraton Hotel, Dayton
March 29-30 Marriott Inn, Cleveland
April 12-13 Perrysburg Inn, Perrysburg (Toledo)

As an organization accredited for continuing medical education, the Ohio State Medical Association Committee on Scientific Work certifies that this continuing medical education activity meets the criteria for 6 credit hours in category I of the Physicians Recognition Award of the American Medical Association. Fee: $60. Contact: Rebecca J. Doll, Director, OSMA Department of Communications, 600 S. High Street, Columbus 43215, phone: 614/228-6971.

March 1978

DIAGNOSIS AND TREATMENT OF MIXED AEROBIC AND ANAEROBIC INFECTIONS: March 16, Community Medcenter Hospital, Marion; Guest Speaker: Dr. Robert Fass, Associate Professor of Medicine and Associate Professor of Medical Microbiology, OSU; contact: Robert R. Tracht, Administrator, 1050 Delaware Avenue, Marion 43302, phone: 614/383-6301.

SURGICAL PHARMACOLOGY: March 16, St. Elizabeth Hospital Medical Center, Youngstown; 4 credit hours; contact: Rashid A. Abdu, M.D., Director of Education, St. Elizabeth Hospital Medical Center, Belmont and Park Avenues, Youngstown 44501, phone: 216/746-7211, ext. 202.

April 1978

TWO-DAY WORKSHOP ON APHASIA: April 3 & 4; University of Cincinnati Medical Center, Cincinnati; sponsor: Division of Audiology and Speech Pathology; Eligible for AMA Category I credit; contact: Dorothy H. Air, M.S., Division of Audiology and Speech Pathology, University of Cincinnati Medical Center, 234 Goodman Street, Cincinnati, Ohio 45267.

ADVANCES IN DIAGNOSTICS AND THERAPEUTICS IN INTERNAL MEDICINE: April 3-5; Medical College of Ohio at Toledo; sponsor: The American College of Physicians, cosponsor: Medical College of Ohio; 18 credit hours; fee: $130 ACP members, FACP, resident and research fellows, $195 nonmembers, $65 Associates; contact: Postgraduate, Department, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104, phone: 215/243-1200.

SURGICAL GYNECOLOGY: April 6, St. Elizabeth Hospital Medical Center, Youngstown; 4 credit hours; contact: Rashid A. Abdu, M.D., Director of Education, St. Elizabeth Hospital Medical Center, Belmont and Park Avenues, Youngstown 44501, phone: 216/746-7211, ext. 202.

CONTINUING EDUCATION IN PSYCHIATRY: April 8; Carrousel Inn, Cincinnati; sponsor: Ohio Academy of Family Physicians; 6 credit hours; fee: $45 AAFP member, $25 FP residents, $55 nonmember; contact: Mrs. Florence I. Landis, Executive Director, Ohio Academy of Family Physicians, 4075 North High Street, Columbus 43214, phone: 614/267-7867.

FOURTEENTH ANNUAL SYMPOSIUM ON RHEUMATIC DISEASES: April 12, 9 AM; Hospitality Inn, Cleveland-Independence, 5300 Rockside Road; sponsor: The Cleveland Rheumatism Society and The Arthritis Foundation; 6 credit hours; fee: $16, no fee for students, interns and residents; contact: Muhammad Asim Khan, M.D., c/o Pat Saccany, The Arthritis Foundation, 2239 East 55th Street, Cleveland 44103, phone: 216/361-5000.

SYMPOSIUM ON MALIGNANT MELANOMA: April 12, The Cleveland Clinic, Cleveland; 6 credit hours; fee: $40; contact: Center for CME, The Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-/5696.

PASSAGES—FAMILY RELATIONS WORKSHOP: April 14-16; Salt Fork Lodge, Cambridge; sponsor: Ohio Academy of Family Physicians; 7 credit hours; fee: $45 AAFP member, $35 residents, $70 nonmember; contact: Mrs. Florence I. Landis, Executive Director, Ohio Academy of Family Physicians, 4075 North High Street, Columbus 43214, phone: 614/267-7867.

BREAST CARCINOMA: April 20, St. Elizabeth Hospital Medical Center, Youngstown; 4 credit hours; contact: Rashid A. Abdu, M.D., Director of Education, St. Elizabeth Hospital Medical Center, Belmont and Park Avenues, Youngstown 44501, phone: 216/746-7211, ext. 202.

ONE-DAY SEMINAR ON GYNECOLOGIC SURGERY AND ONCOLOGY: April 20, 8 AM-5 PM; University of Cincinnati Medical Center, Cincinnati; sponsor: Department of Obstetrics and Gynecology and CONMED; 5¾ credit hours; fee: $65 physicians, $35 residents; contact: Office of CONMED, University of Cincinnati Medical Center, 231 Bethesda Avenue, Cincinnati 45267, phone: 513/872-5486.

PEDIATRIC SURGERY: April 27, St. Elizabeth Hospital Medical Center, Youngstown; 4 credit hours; contact: Rashid A. Abdu, M.D., Director of Education, St. Elizabeth Hospital Medical Center, Belmont and Park Avenues, Youngstown 44501, phone: 216/746-7211, ext. 202.

May 1978

DIVERTICULAR DISEASE: May 9, 8:30 AM; Riverside Methodist Hospital, Columbus; 1 credit hour; contact: Mrs. Joyce Miller or Ms. Karen Saslaw, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

Come to Dayton

1978 OSMA Annual Meeting
Preliminary Schedule of Events

Continuing medical education is the main theme for the 1978 OSMA Annual Meeting, May 6-10. Virtually every program will qualify for Category I or II credit. Particular attention should be taken of the Friday afternoon, May 5 program on Basic Life Support followed by Advanced Life Support on Saturday and Sunday, May 6 and 7. Also, Saturday and Sunday will feature programs on negotiations, development and evaluation of A/V instructional material, and medical writing. These programs are being offered prior to the opening of the House of Delegates on Sunday evening to give all physicians the opportunity to participate in continuing medical education courses.

Early morning post-graduate courses will be held on Tuesday and Wednesday mornings. Pfizer dialogue presentations will also be held on Tuesday. In addition, most scientific sections and specialty societies will participate with programs at the Annual Meeting.

The Ohio Medical Political Action Committee (OMPAC) will have its annual luncheon on Tuesday, May 9 starting with a reception at 11:30 AM followed by lunch. Robert D. Novak, Washington columnist, will be the guest speaker. Mr. Novak has been the OMPAC speaker on several other occasions.

The social function is a dinner and theatre evening at Wright State University. The theatre department assures us a fantastic production of "Cabaret." The evening will be dedicated to Ohio's own John H. Budd, M.D., President of the AMA.

The opening session of the House of Delegates will feature the Montgomery County Glee Club, directed by OSMA Councilor W. J. Lewis, M.D. The final session of the House will convene at 3:30 PM, Wednesday, May 10.

The following is a preliminary schedule of events for the 1978 OSMA Annual Meeting:

May 5 - 10, 1978, Dayton

Headquarters Hotel — Stouffers Dayton Plaza
Coheadquarters Hotel — Sheraton-Dayton Downtown
Exhibits and Scientific Meetings — Dayton Convention and Exposition Center

Friday, May 5, 1978

Basic Life Support	1 — 6 PM

Saturday, May 6, 1978

Registration	8 AM — 3 PM
Advanced Life Support	8 AM — 6 PM
Art of Negotiations	8 AM — 5 PM
Development and Evaluation of A/V Instructional Material	8:30 AM — 5 PM
Course on Medical Writing (Preparation of Scientific Papers for Medical Journals)	10 AM — 12 Noon
Ohio Psychiatric Association	
Council Meeting	5 — 7 PM
Dinner	6 PM

Sunday, May 7, 1978

Advanced Life Support	8 AM — 6 PM
Art of Negotiations	8 AM — 4 PM
Development and Evaluation of A/V Instructional Material	8:30 AM — 4 PM
Course on Medical Writing	10 AM — 12 NOON
Ohio Psychiatric Association and Internal Medicine	9 AM — 3 PM
Lunch	12 NOON
OSMA Delegation to AMA	2 — 4 PM
House of Delegates	
Registration	3 — 7 PM
Buffet Dinner: Delegates, Alternates, OSMA Council, and Official Guests	5:30 PM
First Business Session	7 — 9 PM
Councilor District Caucuses	4 — 5:30 PM
Montgomery County Glee Club Concert	9:30 PM

Monday, May 8, 1978

Complimentary Buffet Breakfast Delegates, Alternates, OSMA Council, and Official Guests	7 — 8 AM
Reference Committee Hearings	7:30 AM — 12 NOON Resume 1:30 PM if necessary
Resolutions Committee 1	
Resolutions Committee 2	
Resolutions Committee 3	
President's Address	
Nominations	
Visitation of Dayton Medical Facilities Via bus	8 AM — on
General and Advance Registration	8:30 AM — 5 PM
Dermatology	9 AM — 4:30 PM
Otolaryngology	9 AM — 5 PM
Lunch	12 NOON

(continued on page 184)

The next best thing to a 25-hour day.

Designed exclusively for the kind of physician who could use at least 25 hours in every day, 8 days a week, 53 weeks a year. The kind of physician who recognizes the value of efficiency in everything from speed reading to a skilled head nurse. Because that's the kind of physician who knows that a more efficient practice is the key to more efficient patient care.

And that's what we're all about.

The Physician's Computer Data System is pre-programmed exclusively to handle the physician's needs. Needs such as: insurance forms, patient records, billing, and other ledger information. And all of it in a fraction of the time it takes a person to do it.

But just about any person can be taught to operate it. Anyone that you choose from your staff will be trained at the same time we install the System and feed it your files and records.

They won't have to learn any special "computer talk" either. Because the Physician's Computer Data System is programmed in the same plain language as we're using here. Even the three component parts which make up the System are called quite plainly: the Computer, the Printer, and the Terminal.

And the Physician's Computer Data System will slip as easily into your budget as it does your everyday office procedure and staff makeup. With a leasing program of just $385 a month. (That includes installation and training.)

So maybe we can't give you that 25th hour a day. But with the Physician's Computer Data System, you get just a little more out of 24.

The computer data system developed exclusively for the physician.

Send for complete details.

Microtech, Inc.
1127 S. Sixth St.
Louisville, Kentucky 40203

Name_____

Address_____

City_____ State_____ Zip_____

THE PHYSICIAN'S COMPUTER DATA SYSTEM, by MICROTECH.

Preliminary Schedule *(continued)*

Neurology
- Lunch — 12 NOON
- Meeting — 1:30 — 4:30 PM

Exhibits Open — 12 NOON — 4:30 PM

Culture Show — 12 NOON — 4:30 PM

Rheumatology
- Lunch — 12 NOON
- Meeting — 1:30 — 5 PM

Physical Medicine and Rehabilitation
- Meeting — 1:30 — 4:30 PM

The Legislative Process — 1:30 — 3 PM

Reception for Exhibitors — 5 — 6 PM

OMI Reception — 5 — 6:30 PM

Jefferson Medical College Reception — 6 PM

Medical Mutual Reception — 9 PM

Tuesday, May 9, 1978

Postgraduate Courses — 7:30 — 9:30 AM

Course 1. Electrolytes and Blood Gases — Leon Cudhowitz, M.D.

Course 2: Therapeutic Logics and Selection — John Lindower, M.D.

Course 3: How to Deal with the Alcoholic Patient in Practice — Abraham Heller, M.D.

Course 4: Pediatric Emergencies — Charles H. Wharton, M.D.

Course 5: Death and Dying — Roger D. Blackwell, Ph.D.

OMPAC Breakfast — 8 — 11 AM

ACME Breakfast — 8 — 11 AM

Ophthalmology
- Breakfast — 8 AM
- Meeting — 10 AM — 4:30 PM
- Lunch — 12 NOON

General and Advance Registration — 8:30 AM — 4:30 PM

Sports Medicine and Family Practice
- Meeting — 9 AM — 12 NOON
- Lunch — 12 NOON

Exhibits — 9 AM — 4:30 PM

Internal Medicine
- Meeting — 9 AM — 12 NOON

Pathology
- Meeting — 9 AM — 4:30 PM

Pfizer Dialogue Presentations
(Tuesday Only)

P1: *Stress and Depression* — Joseph Talley, M.D., Asst. Clinical Professor, Dept. of Family Practice, University of North Carolina — 9 — 10 AM

P2: *Use of Major Tranquilizers in Office Practice* — John Crayton, M.D., Asst. Professor of Psychiatry, University of Chicago — 11 AM — 12 NOON

P3: *Problems in Diabetic Management* — T. S. Danowski, M.D., Clinical Professor of Medicine, University of Pittsburgh School of Medicine — 1 — 2 PM

P4: *Management of the Hypertensive Patient* — Donald G. Vidt, M.D., Head, Dept. of Hypertension and Nephrology, Cleveland Clinic — 3 — 4 PM

Neurosurgery
- Meeting — 9 AM — 4 PM
- Lunch — 12 NOON

OMPAC Luncheon — 11:30 AM — 1:30 PM

Emergency Medicine, Ohio Committee on Trauma, and Directors of Medical Education
- Lunch — 12 NOON
- Meeting — 1:30 — 4:30 PM

Family Practice
- Meeting — 1:30 — 2:30 PM

Dinner and Theater
- At Wright State University — 6:30 PM — 12 MIDNIGHT

Wednesday, May 10, 1978

Postgraduate Courses — 7:30 — 9:30 AM

Course 1: Electrolytes and Blood Gases — Leon Cudhowitz, M.D.

Course 2: Therapeutic Logics and Selection — John Lindower, M.D.

Course 3: How to Deal with the Alcoholic Patient in Practice — Abraham Heller, M.D.

Course 4: Pediatric Emergencies — Charles H. Wharton,

Course 5: Death and Dying — Roger D. Blackwell, Ph.D.

General and Advance Registration — 8:30 AM — 4:30 PM

Ohio Chapter, American College of Chest Physicians
- Meeting — 9 AM — 5:15 PM
- Lunch — 12 NOON

Plastic Surgery
- Meeting — 9 AM — 12 NOON

Allergy and Immunology
- Meeting — 9 AM — 12 NOON
- Lunch — 12 NOON

Exhibits — 9 AM — 12 NOON

Anesthesiology
- Meeting — 1:30 — 4:30 PM

Colon and Rectal Surgery
- Lunch — 12 NOON
- Meeting — 1:30 — 4:30 PM

Radiology
- Meeting — 2 — 4 PM

House of Delegates
- Registration — 2:30 — 3:30 PM
- Final Business Session — 3:30 — 6 PM
- Buffet Dinner: Delegates, Alternates, OSMA Council, and Official Guests — 6 — 7 PM

Thursday, May 11, 1978

Council Meeting — 8 — 10 AM

OMPAC Presents
Washington Columnist, Robert D. Novak

At Luncheon in Conjunction With
1978 OSMA Annual Meeting
Tuesday, May 9, 1978



Robert D. Novak

The Ohio Medical Political Action Committee (OMPAC) speaker at the 1978 OSMA Annual Meeting will be Washington columnist, Robert D. Novak. Mr. Novak will address the OMPAC luncheon, Tuesday, May 9, held in conjunction with the OSMA Annual Meeting. The luncheon will begin with a social period at 11:30 AM, followed by lunch at noon. The location is the Stouffers Dayton Plaza.

A part of the writing team of Evans and Novak, whose column "Inside Report" is syndicated in more than 250 newspapers here and abroad, Robert Novak is often described as a news-hungry journalist who specializes in investigation and probing analysis instead of armchair commentary. Robert Novak's name became well respected on Washington's Capitol Hill from his days as Chief Congressional Correspondent for *The Wall Street Journal;* since 1963, when he and Rowland Evans, Jr., joined forces to start their column, their success has been outstanding.

Novak and Evans give appraisals from behind the scenes of significant and unexpected developments on national, state, and local trends as well as cover the international scene. Their reports have been known to come from four different states in one week, and Mr. Novak has crisscrossed the country numerous times to test grass-roots sentiment. He travels abroad frequently, making at least one trip each year.

Robert Novak is a graduate of the University of Illinois and began his newspaper career in his hometown on the Joliet *Hearld News.* After serving with the rank of lieutenant in the Korean War, he joined the Associated Press Omaha office and later continued with the news service in Lincoln, Nebraska and Indianapolis. In 1957, he went to Washington as Capitol Hill correspondent for the Associated Press. He transferred to *The Wall Street Journal* in 1958 as Senate correspondent and political reporter, later becoming their chief congressional correspondent.

Since 1963, he and Rowland Evans, Jr., have been writing "Inside Report" and a biweekly newsletter, the "Evans-Novak Political Report." Mr. Novak has also written *The Agony of the G.O.P.* (1964) and, with Mr. Evans, wrote *Lyndon B. Johnson: The Exercise of Power* (1966) and *Nixon in the White House* (1971).

OMPAC LUNCHEON REGISTRATION FORM

____Tickets @ $10/ticket. Total remittance: $_____

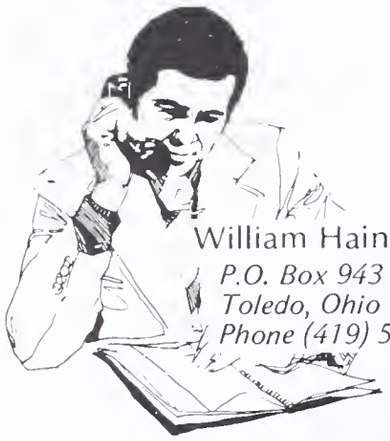
Make checks payable to: Ohio State Medical Association

Name_____
(Please Print)

Address_____
(Street) (City) (State) (Zip)

I am
- ☐ OSMA Member
- ☐ Non-member Physician
- ☐ Other_____
- ☐ Medical Student
- ☐ Guest
- ☐ Please prepare guest badge for my spouse.

Mail form to:
Department of Continuing Medical Education, Ohio State Medical Association,
600 South High Street, Columbus, Ohio 43215



William Hainen
P.O. Box 943
Toledo, Ohio 43656
Phone (419) 535-8041

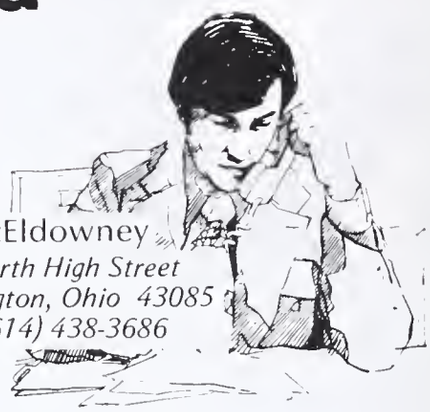


Dan Negron
2400 Market Street
Youngstown, Ohio 44507
Phone (216) 783-9800

Your Blue Shield Expert



Frank Petsche
1351 Wm. Howard Taft Road
Cincinnati, Ohio 45206
Phone (513) 872-8381



Frank McEldowney
6740 North High Street
Worthington, Ohio 43085
Phone (614) 438-3686

THEY'RE HANDY PEOPLE TO HAVE AROUND

When you have a question, problem or concern about Blue Shield, we have the people who can help—your Ohio Medical Indemnity professional relations experts. Located right in your area, it's their job to short-cut...both physically and administratively...the distance between your office and our main office.

They're the people to call to get answers and action and save yourself time and trouble. They're nearby when you need help...and they'll go out of their way to see you get it.

If by some chance you haven't gotten acquainted with your Blue Shield professional relations experts, give them a call today. You'll find they're handy people to have around.

Blue Shield

Ohio Medical Indemnity, Inc.

John C. Reeve, M.D., Pioneer Dayton Physician (1826-1920)

Katherine T. Barkley

DR. JOHN C. REEVE, who lived from 1826 to 1920, was a founder of the American Gynecological Society and Chief of Staff of St. Elizabeth's Hospital, Dayton, Ohio for 30 years. When he was 93 years of age, he wrote an autobiographical sketch in which he noted that during his lifetime, the whole world had changed. Among other happenings, this period was marked by adoption of asepticism and the concept of anesthesia in surgery; the coronation of William IV, Victoria's predecessor; and the great meteor shower of 1833, all of which Reeve witnessed.

John Reeve's family immigrated to the United States in 1832, believing a change in climate would be beneficial for his father's asthma. They arrived in Cleveland, then a town of 1,500 people. Later that decade, President Jackson's war with the United States Bank brought financial disaster to John's father; and it seemed necessary for John to leave home and make his own way.

His first job was in the printing office of a weekly paper called the *Cleveland Advertiser,* a forerunner of *The Plain Dealer.* Later, Reeve entered the office of the *Daily Herald.* He found that working for a daily paper gave him no leisure time for when the paper came off the press in the evening, John was responsible for delivering newspapers to homes.

Therefore, he decided he would like to be a teacher although he would receive less pay than he did as a printer. At 17 years of age, in the winter of 1843-1844, John started to teach in a school about 16 miles from Cleveland. The next year, he taught at another school. A dream came true that spring when John Reeve attended a session at an academy at Kirtland, Ohio. This was the first time he had attended school since he was 12 years old.

In 1845, President Polk appointed John's brother-in-law postmaster of Cleveland. John became clerk in the postoffice. Many letters arrived from Germany, and John determined to learn German so that he could read the addresses on the letters. He sent to Boston for a German grammar and started a study of the German language, which became immensely useful later in his study of medicine.

Ms. Barkley, Cincinnati, Medical Librarian, Jewish Hospital, Cincinnati, Ohio
Submitted March 17, 1977.

Medical Education

John Reeve attended Cleveland Medical College from 1847 to 1848. Classes were large. Dr. Horace A. Achley was professor of surgery; Dr. Samuel St. John taught chemistry; and Dr. Jared Potter Kirtland was a fine horticulturist. The library was small and seldom used. Saturday afternoons were devoted to clinics with services provided free of charge.

Prior to this period of study, Reeve followed the practice of the time when entering the medical profession: a student read for three years in the office of a practitioner and attended two lecture courses. As there were no requirements, anyone who desired to do so could enter the study of medicine. Reeve paid Dr. John Delamater $50 for the privilege of working in his office. Dr. Delamater was a man of high reputation, an "old-time" physician.

Among John Reeve's fellow students were Proctor Thayer, later a professor of surgery; and Henry K. Cushing, who also became a professor in the Medical Department of Western Reserve College. Dr. Cushing was the father of Harvey Cushing, who became an internationally famous surgeon. The students read Carpenter's *Physiology,* Churchill's *Midwifery,* Watson's *Practice,* and William's *Principles.*

Reeve said he never saw a gynecologic instrument, and there was little practical experience during his study time. He did not see any patients in the office to learn symptoms and means of diagnosis. Also, there was no instruction in treatment. However, a good amount of pharmacy was learned as there were shelves of medicines in the office, which the students dispensed upon prescriptions from Dr. Delamater.

Dr. Reeve looked back at his education and the medical profession with the following observation:

> Those who would bow the head in shame over the faults of medicine in the past, may be consoled by recalling the fact that to err is human and that the history of two other great professions record errors even greater than those of medicine. For ages the law inflicted torture to compel confession; the church resorted to the rack and the stake to establish belief. The physician of 1919 may stand erect and point with pride to the records of his profession, to the victory over smallpox, to the control over the great white plague, to the easing of childbirth, and the elimination of pain in surgery—and above all he can glory in the victories of preventive medicine.

Early Practice

In 1849, John Reeve decided to marry and to start a practice. He married Emma J. Barlow of Cleveland,

who proved a fine companion and helpmate. He had not yet received his medical degree; but all that remained for him to do was read, and he felt he could do this after entering practice. As he looked back on this venture, Reeve was astounded at the nerve he had to start practice with no instruction in diagnosis or treatment, never having performed an operation on the living or dead, and never having delivered a baby or attended a birth.

John and Emma Reeve settled in a village in a wooded area of Dodge County, Wisconsin. There were two other medical practitioners in residence. One, a medical-school graduate, resented Dr. Reeve's intrusion. The other was an older man, an herb doctor with many other talents. When a settler accidently injured his wife with a falling tree, the doctor attended her until she died, then made her coffin, and finally preached her funeral.

Hardships were innumerable. Money was unbelievably scarce, and Reeve could not even purchase what he needed for making medicines. He received exactly $68 during his first year of practice. There were two epidemics of smallpox, and Dr. Reeve was impressed with the terrible disfiguration most victims suffered. He related calling a consultant to diagnose a disease. The consultant called it "erysipelas," but Reeve was positive that it was necremia, a case of smallpox in which the patient died before the eruption appeared.

In his second year of practice, the doctor was called to a farm to care for a farmer whose arm had been mangled in a threshing machine. The nearest surgeon was a day's trip away, and the only course of action was immediate amputation. Reeve improvised a tourniquet and used his pocket knife plus a carpenter's sash saw. Another doctor, just as inexperienced, administered chloroform under Reeve's direction. The worst part was the long night after, when Reeve lay on the floor dreading any complications and hemorrhage that might ensue. However, the patient recovered and told the story for many years.

With honest pride, Reeve spoke of performing an amputation under such primitive conditions; but he thought it even more remarkable that a man named John L. Richmond had performed the first cesarean section in 1827 near Cincinnati. Dr. Richmond operated in a log cabin by candlelight surrounded by flood waters and wind gales. In 1830, he reported the case in *Drake's Western Journal of the Medical and Physical Sciences.*

In the summer of 1853, Reeve made a journey to Cleveland to take his examination and to receive a medical degree. The doctor described his life in Wisconsin as dreary, dull, and isolated, with the weekly mail as the only bright spot. He subscribed to one medical journal sent from Boston even though his preceptor had advised against reading medical journals, feeling this would make students unsound and confused. In addition, he had a small collection of medical books, the weekly newspaper, Harper's monthly, and *Uncle Tom's Cabin.*

When he had a chance to sell his practice, he did so with great joy and went East. He intended to do some post-graduate work at the University of Pennsylvania in Philadelphia. However, while in Cleveland, a friend suggested Reeve accompany him to the University of Göttingen in Germany for continued study in medicine. This idea was too good to ignore. Dr. Reeve secured a stipend from a newspaper for travel reporting, and Mrs. Reeve volunteered to go back to teaching school so that her husband could take his trip.

Foreign Travels

In New York, they found a German brig that would take them aboard as passengers. The journey was dull and uninteresting, and Dr. Reeve saw a chance to get off on a fishing boat and stop at London. It was difficult to find study courses which he would take. He was allowed to be a sort of guest in the classes, but he could not participate in the courses.

There was a hospital ship named "Dreadnought" in the harbor, and here he found the experience he had been seeking. Sailors from all over the world came to this hospital ship. There were many deaths, and the dead room was never empty. Conditions were ideal for operating on cadavers. Down in the hold of this ship, he studied anatomy to his heart's content.

In England, Dr. Reeve also had the opportunity to study obstetric anesthesia. His interest in this area began when he observed the first administration of ether as an anesthesia in Ohio prior to his year in medical school. The fact that Queen Victoria permitted the use of chloroform anesthesia during her confinement served to inform the public of the great potential of anesthesia. Reeve felt she should be acclaimed for this decision.

Reeve also was privileged to study under John Snow, whose work on chloroform Reeve considered to be of the highest scientific character. Although chloroform had many advantages over ether, more danger was associated with chloroform. These statistics prompted Reeve to collect data pertaining to deaths from chloroform. This study began his work on anesthesia, which supplied the subject matter for many journal articles. In fact, the Western Reserve University conferred an honorary degree on him "for literary contributions to medicine."

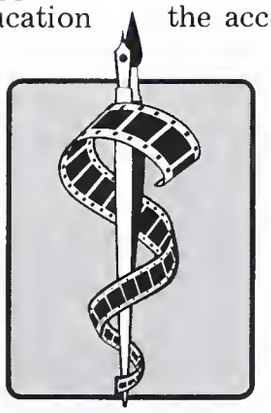
The trip to London instilled in Dr. Reeve a high sense of the dignity and worth of the practice of medicine. Since his youth had been spent in manual labor and his early years of practice were entirely devoid of professional companionship, he had never before experienced this sense of dignity. He felt most strongly that a foundation of classical study should be a requirement in the education of a first-class physician.

From London, he proceeded to his original destination of Göttingen, a town famous for its university. The most prominent man on the faculty was Ed von Siebold, Professor of Obstetrics; and Dr. Reeve enrolled in his course. Here at last was clinical instruction. There was a gynecologic clinic two days a week, with about three deliveries each week. Patients were mostly from the peasant class. The student was permitted to make examinations, describe conditions, and answer questions regarding findings.

(continued on page 190)

The Uninformed Patient– An Unnecessary Risk

Physicians are being sued often and successfully. Yet a large percentage of these liability suits have no medical or legal merit. We at Jeppesen Sanderson believe patient education that is comprehensive and also documented is an essential part of the solution to this unnecessary phenomenon.



MED PREP or Medical Patient Risks Education Program was developed for this purpose. The MED PREP Library is planned to consist of over 200 audiovisual presentations covering 16 specialties. A particular medical or surgical procedure is described in each film along with a number of significant potential risks and, in most instances, some possible alternative courses of treatment.

The MED PREP information is presented in easy-to-understand language and in a warm and personal manner. After viewing the film and being given the accompanying briefing folder, the patient signs the tear-off form which then can become a part of the physician's permanent file on that patient.

MED PREP provides sensitive and perceptive patient briefings and documents that the information has been received. MED PREP is being distributed by several medical societies and associations and is now available to physicians. For more information about MED PREP, contact Ohio State Medical Association, 600 South High Street, Columbus, Ohio, 43215 or call 614-228-6971.

JEPPESEN SANDERSON

8025 East 40th Avenue, Denver, Colorado 80207 • (303) 320-6070



After travel throughout Germany, Switzerland, and on to Paris, where he observed Alfred Armand Louis Marie Velpeau teaching a class in surgery, John Reeve decided to return to Cleveland. With only $25, he decided to board a ship employed as a medical officer. However, he discovered that a British medical degree was required to qualify as a medical officer for a ship with 500 or more passengers. After about three weeks, he found a ship with fewer passengers whose captain would hire him.

Practice in Ohio

Arriving in Cleveland, with one dime, Reeve found the warehouse containing his household goods and medical books and equipment had burned to the ground. And so John Reeve came to what he considered the beginning of his career, previous years having been spent trying to become a well-educated physician.

John Reeve and his wife moved to Dayton, where he established a practice. In the early 1860s after some years in Dayton, he was appointed Professor of Materia Medica at the Medical College of Ohio, Cincinnati. Around the same time, Reeve accompanied Dr. George C. Blackman in treating the Civil War wounded. Dr. Blackman performed the surgery, and Dr. Reeve administered the anesthetic.

When the war was over, Dr. Reeve decided to return to his practice in Dayton rather than continue teaching in Cincinnati; he was so successful in his practice that his fame spread to other parts of the country. In 1859, he had published a translation of Flouren's *History of the Discovery of the Circulation of the Blood.* In 1869, he introduced the subject of medical thermometry to the profession in a review of a book on the subject by Carl Wunderlich. It was said that the reader began the book thinking that fever was a disease and finished it knowing that it was a symptom. His accounts of the use of anesthetics were numerous and finely documented.

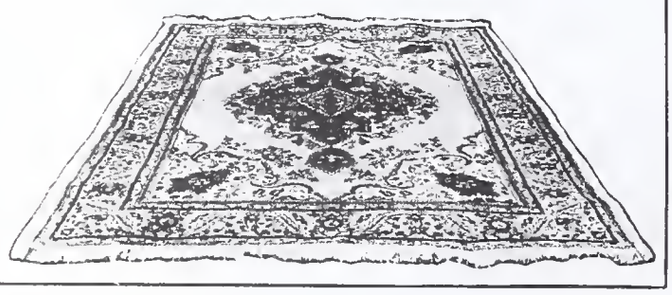
In Columbus
for over 65 years, since 1909,
K. A. Menendian
has been known for
the finest quality and best values in
ORIENTAL RUGS.

We carry a complete selection of rugs from mats to mansion sizes. Over 1500 rugs in stock from Iran, India, China, Pakistan, Turkey, etc.

See over 4,000 samples in our newly remodeled carpet showroom from Karastan and other fine mills.

We specialize in Oriental rug cleaning and repairing.

K.A.Menendian
1090 West Fifth Avenue
294-3345



Contributions to Medicine

Because of his many contributions, Dr. Reeve was the recipient of many honors. He was a founder of the American Gynecological Society, serving as Vice-President in 1887 and becoming an Honorary Fellow in 1897; an Honorary Fellow of the American College of Physicians, Philadelphia; President of the Ohio State Medical Society; President of the Montgomery County Medical Society; and a member of the American Medical Association. He was organizer and first president of the medical staff of the Hospital of the Sisters of the Poor of St. Francis, which later became St. Elizabeth Hospital, the first hospital in Dayton.

In one paper entitled "The Discovery of Surgical Anesthesia," Reeve related the story of Clement Vallandigham at the Golden Lamb Inn, Lebanon, Ohio. Vallandigham was known as a statesman and leader of the area "Copperheads" during the Civil War. President Lincoln had to intervene when he was arrested for "sympathy for the enemy," changing his prison sentence to a "banishment beyond enemy lines," thus giving Vallandigham a chance to escape to Canada. Vallandigham was later nominated for Governor of Ohio and served in the Ohio Legislature. In 1871, he became defense attorney for Thomas McGehean of Hamilton who was charged with the murder of Thomas Meyers. Due to the prejudiced opinion in Hamilton, the trial location was changed to Lebanon. In a room on the second floor front of the Golden Lamb Inn, the Honorable Clement Vallindigham shot himself while trying to demonstrate that Meyers must have done the same thing. Dr. Reeve was Vallandigham's personal physician and was called by telegram to come to Lebanon. Dr. Marion Sims telegraphed Dr. Reeve, advising him to open the abdomen and to do what he could. This action was not then suggested in textbooks on surgery. Mr. Vallandigham passed away before the message was received. Dr. Reeve thought that because of aseptic surgery, had the operation been performed immediately, his life might have been saved.

Summary

John C. Reeve was highly respected; he was considered by the community to be unselfish, generous, interested, and thoughtful — an ideal physician and man. Reeve outlived most of his friends in the medical profession. As one writer noted, those friends were among the most eminent in the country — Alexander J. Skene of Brooklyn, Samuel D. Gross of Philadelphia, O. Marion Sims of New York, Alexander Dunlap of Springfield, George C. Blackman of Cincinnati, John Shaw Billings, Theophilus Parvin, and many more. Reeve died of pneumonia at the age of 94 years, and his son, Dr. J. C. Reeve, Jr., succeeded him as a practicing physician. The elder John C. Reeve was so alert mentally at 94 that, upon the request of Professor Wilder of Cornell, his brain was bequeathed to that University for study.

"Texas physicians report on a self-administered peritoneal dialysis system...Dr. Salk protests widespread news reports of imminent cure for multiple sclerosis...a survey of malpractice cases uncovers the most common causes of claims...Canadian cardiologists offer a technique for diagnosing angina caused by coronary-artery spasm...the IRS is clamping down on tax shelters but some programs still work...CT scanning is shown to detect hidden abdominal injuries resulting from auto accidents.."

Important things are happening that you should know about right away. You'll find them on your desk every two weeks in Medical World News, the newsmagazine of medicine.

Read this one first.

medical world news

A McGraw-Hill publication

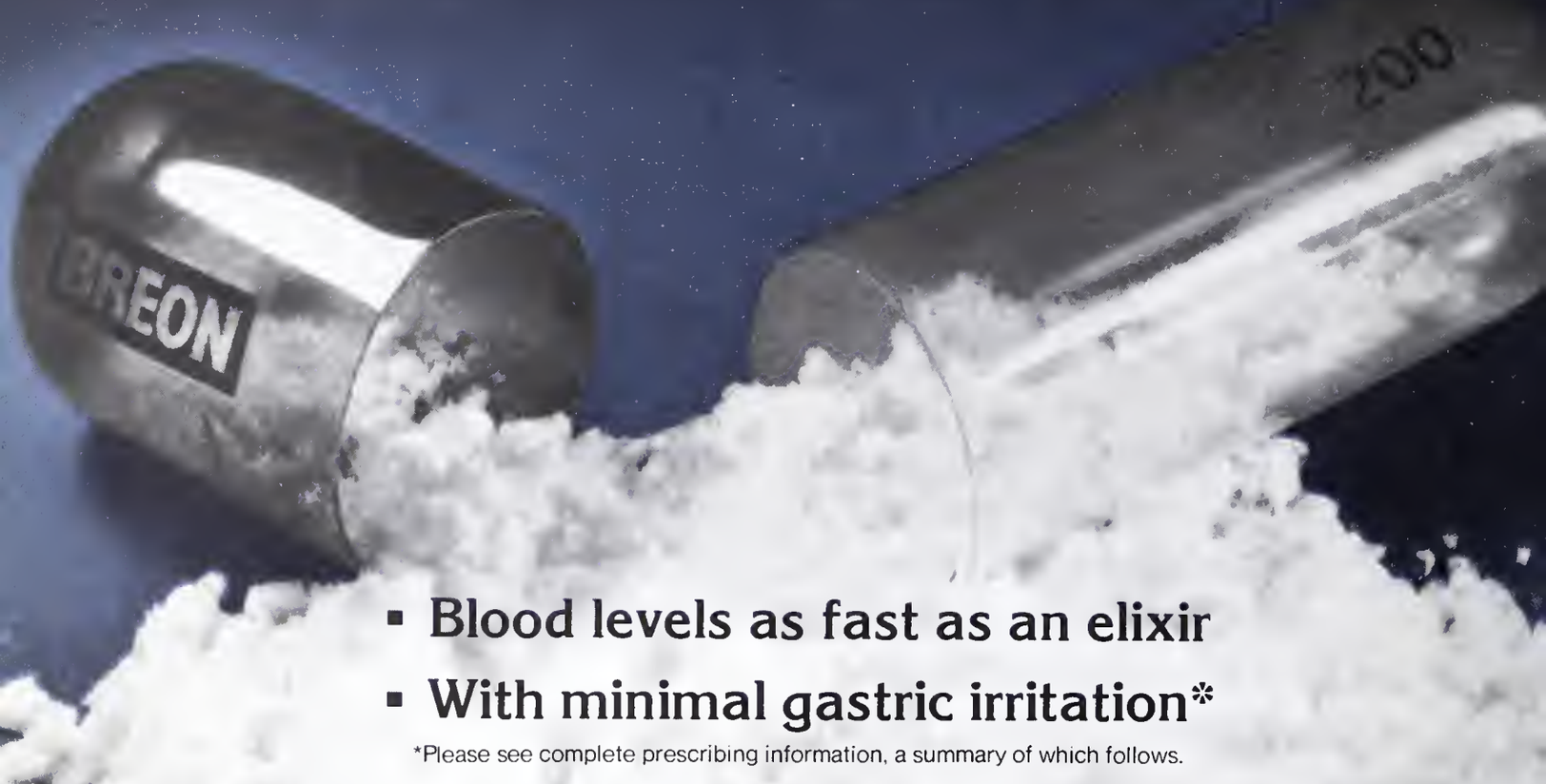


A Difference in Theophylline Therapy

micro-pulverized

BRONKODYL® Capsules

brand of theophylline, USP anhydrous



- **Blood levels as fast as an elixir**
- **With minimal gastric irritation***

*Please see complete prescribing information, a summary of which follows.

DESCRIPTION:
Each green and white hard gelatin capsule contains theophylline USP anhydrous, 200 mg., in a micro-pulverized form. Each brown and white hard gelatin capsule contains 100 mg. The elixir contains 80 mg. theophylline per 15 ml. in a 20% alcohol elixir (approximately 20 calories, 0.9 gm carbohydrate per tablespoonful).

ACTION: Theophylline is a methylxanthine which relaxes the smooth musculature of the bronchioles through its inhibition of the conversion of cyclic adenosine monophosphate to adenosine monophosphate by phosphodiesterase. It also has diuretic, cardiotonic, and CNS stimulant effects.

INDICATIONS: Bronkodyl is indicated for symptomatic relaxation of bronchiolar spasm in the chronic obstructive bronchopulmonary diseases; e.g., bronchial asthma, chronic bronchitis and pulmonary emphysema.

CONTRAINDICATIONS: Bronkodyl is contraindicated in persons known to have had serious idiosyncratic responses to theophylline, its salts, or the other methylxanthines, theobromine, or caffeine and may be contraindicated in peptic ulcer.

WARNINGS: All methylxanthines should be used with caution in children and in others who are currently taking bronchodilator products, especially in rectal dosage form, which may contain theophylline or related drugs.

USAGE IN PREGNANCY: Although theophylline has been used for many years, with no evidence of adverse fetal effect or teratogenicity, its safety in pregnancy has not been established. Therefore use of Bronkodyl during lactation or in women of childbearing potential requires that possible benefits of the drug be weighed against possible hazards to fetus or child.

PRECAUTIONS: Bronkodyl should be used with caution in patients with cardiac or circulatory disease.

ADVERSE REACTIONS: Gastrointestinal: Epigastric distress, nausea, vomiting. Cardiovascular: palpitations. CNS: Insomnia, restlessness, irritability, convulsion.

DOSAGE AND ADMINISTRATION: Adults: Usual dosage of Bronkodyl is 200 mg. every 6 hours (four doses in each 24 hours). This dosage may be adjusted to reflect individual clinical response as an indication of slow or rapid metabolism of the drug. If adverse reactions are encountered, each dose may be reduced, or the interval between doses may be lengthened, or both. If clinical response is not satisfactory, indicating possible rapid inactivation of the drug, dosage may be gradually increased to achieve the desired response. In some instances of either too slow or too rapid metabolism, plasma levels of theophylline should be determined and dosage adjusted accordingly to achieve levels above 10 mcg/ml, but not to exceed 20 mcg/ml.

Dosage in Children: Usual dosage should be based on administration of 10 mg per kg per 24 hours, divided in 4 doses per day, given every 6 hours. As this may not be possible with use of the capsules, Bronkodyl elixir may be used. Theophylline saliva levels (approximately 60% of simultaneous blood levels), may facilitate dosage adjustments, especially in children, to obtain appropriate response.

HOW SUPPLIED:
Bronkodyl 100 mg., brown and white capsules in 100's, Code #1831.
Bronkodyl 200 mg., green and white capsules in 100's, Code #1833.
Bronkodyl Elixir, 80 mg. per 15 ml, in pints, Code #1835.

BREON LABORATORIES INC.
90 Park Avenue, New York, N.Y. 10016

OSMA Placement Service Ads

In order to promote retention in Ohio of physicians who trained in the State, ***The Journal***, in cooperation with the OSMA Department of Field Service, offers classified advertising listings at no charge to physicians-in-training desiring to practice in Ohio. Persons eligible for this service must be graduates of Ohio medical schools and/or persons who are completing an internship or residency program at an Ohio institution. They must also be currently in a medical training program or in the United States Armed Forces (or some other U.S. government service).

All classified ads will be printed anonymously by use of box numbers in a special classified ad section of ***The Journal***. Replies to the ads will be channeled through the Department of Field Service, which will assist in the location process. (Replies are otherwise confidential.) Ads will be printed as frequently as space permits. (See previous issues of ***The Journal*** for additional listings.)



INTERNIST: With cardiology subspecialty available July 1978. Diplomate of the Board of Internal Medicine. Eligible for the specialty board examination in cardiology in 1978. Desires community that is rural with metropolitan ties or suburban metropolitan with population of 15,000-100,000. Prefers solo or small group practice. Contact Box P-25 c/o Ohio State Medical Journal.

INTERNIST: Available July 1978. Desires location in areas 1, 2 or 3 in suburban metropolitan or metropolitan community with population of 100,000 to 1 million. Prefers group practice or position as house physician. Eligible for specialty board examination in July 1978. Contact Box P-24 c/o Ohio State Medical Journal.

PEDIATRICIAN: Currently available. Desires location in community that is rural with metropolitan ties or suburban metropolitan, population 15,000 to 100,000. Interested in group or institutional practice. Eligible for specialty board examination June 1977. Contact Box P-11 c/o Ohio State Medical Journal.

OBSTETRICIAN / GYNECOLOGIST: Available July 1978. Desires community that is rural with metropolitan ties or suburban metropolitan with population 50,000 to 100,000. Prefers solo or small group practice. Eligible for specialty board examination July 1978. Contact Box P-12 c/o Ohio State Medical Journal.

UROLOGIST: Available July 1978. Desires suburban metropolitan area, population 50,000-100,000. Interested in solo or small group practice. Eligible for specialty board examination May 1978. Contact Box P-1 c/o Ohio State Medical Journal.

SURGEON: General. Available July 1978. Desires rural area with metropolitan ties, population 15,000-50,000. Prefers group practice of 6 or more members. Eligible for specialty board examination June 1978. Contact Box P-15 c/o Ohio State Medical Journal.

ANESTHESIOLOGIST: Currently available. Desires small group practice in metropolitan area with population 50,000-500,000. No preference as to area of state. Contact Box P-10 c/o Ohio State Medical Journal.

SURGEON: General with thoracic and cardiovascular subspecialty. Available December 1977. Desires community that is rural with metropolitan ties, suburban metropolitan, or metropolitan. Population 50,000 to 500,000. Eligible for board examination in general surgery 1975. Contact Box P-4 c/o Ohio State Medical Journal.

INTERNIST: With cardiology subspecialty available July 1978. Diplomate of the Board of Internal Medicine. Eligible for the specialty board examination in cardiology July 1978. Desires location in areas 1, 2, 3, or 5 in suburban metropolitan or metropolitan community with population 100,000 to 1 million plus. Prefers cardiology group with part-time academic appointment. Prefers invasive cardiology, but willing to do noninvasive. Contact Box P-2 c/o Ohio State Medical Journal.

PSYCHIATRIST: Also general medicine. Available July 1978. Desires location in suburban metropolitan, metropolitan, or inner city community in areas 1, 4, or 5. Population 15,000-1-million. Very flexible as to type of practice. Eligible for specialty board examination July 1978. Contact Box P-6 c/o Ohio State Medical Journal.

INTERNIST: Subspecialty in pulmonary medicine. Diplomate of the Board of Internal Medicine. Eligible for specialty board examination in pulmonary medicine June 1978. Desires location in community that is rural with metropolitan ties, suburban metropolitan, metropolitan, or inner city. Population 15,000-1 million plus. No preference as to area of state. Very flexible as to type of practice. Contact Box P-9 c/o Ohio State Medical Journal.

OBSTETRICIAN / GYNECOLOGIST: Available July 1978. Desires community that is rural with metropolitan ties, suburban metropolitan, or metropolitan. Population 15,000 to 500,000. Interested in group practice with part-time academic appointment. Eligible for specialty board examination July 1978. Contact Box P-3 c/o Ohio State Medical Journal.

UROLOGIST: Available July 1978. Desires community that is rural with metropolitan ties, suburban metropolitan or metropolitan. Population 50,000 to 500,000. Interested in solo or group practice. Eligible for specialty board examination May 1978. Contact Box P-13 c/o Ohio State Medical Journal.

INTERNIST: Available July 1978. Desires location in areas 1, 4, or 5 in community that is rural with or without metropolitan ties. Population to 50,000. Prefers group practice with part-time academic appointment. Eligible for specialty board examination July 1978. Contact Box P-8 c/o Ohio State Medical Journal.

PEDIATRICIAN: Available July 1978. Desires location in areas 1, 2, or 5 in community that is rural with metropolitan ties or suburban metropolitan with population 15,000-50,000. Prefers small group practice. Eligible for specialty board examination May 1978. Contact Box P-16 c/o Ohio State Medical Journal.

SURGEON: General. Available July 1978. Desires location in area 3 in community that is rural with metropolitan ties, suburban metropolitan, or metropolitan. Population 50,000-100,000. Prefers group practice. Eligible for specialty board July 1978. Contact Box P-5 c/o Ohio State Medical Journal.

OBSTETRICIAN / GYNECOLOGIST: Available July 1978. Desires location in areas 1, 2, 3 or 5 in suburban metropolitan or metropolitan community with population 50,000-500,000. Prefers group practice. Eligible for specialty board examination June 1978. Contact Box P-14 c/o Ohio State Medical Journal.

Make Your Hotel Reservations

for the

1978 OSMA Annual Meeting

DAYTON, OHIO MAY 6-10

STOUFFER'S DAYTON PLAZA HOTEL ..... **5th and Jefferson Streets**
(OSMA Headquarters)
Single $27
Double $32

SHERATON DAYTON DOWNTOWN ..... **21 S. Jefferson Street**
(OSMA Co-Headquarters)
Single $24
Double $30

RAMADA INN / Downtown ..... **330 W. First Street**
(Auxiliary Headquarters)
Single $20
Double $25

HOLIDAY INN / Downtown ..... **404 W. First Street**
Single $23
Double $31

All rates subject to change. If you plan to share a room, please indicate name of roommate.

HOTEL RESERVATION BLANK

(Mail to Hotel of Choice)

_____
(Name of Hotel)

_____ Dayton, Ohio
(Address)

Please reserve the following accommodations during the period of the Ohio State Medical Association Annual Meeting, May 6-10, 1978 (or for period indicated). (Note: In order to accommodate you, please make reservations by April 15, 1978.)

_____ Single Room _____ Other Accommodations

_____ Double Room

Price Range _____ Guaranteed _____

No. of Persons _____ Arrival Date _____ Hour of Arrival _____ Departure Date _____

Name _____

Address _____

City _____ State _____ Zip _____

PLEASE VERIFY MY RESERVATION

If Rate or Accommodation requested not available, next highest rate or accommodation will prevail.
Rooms will be held until 6 PM unless payment is guaranteed.

Classified Ads

Rates: $3 per line. Display classified: $5 per line. Minimum 3 lines per insertion. Ads measure 8 lines to the inch. Box number reply: Flat $5 charge in addition to line cost for up to and including three insertions. (Covers cost of mailing replies which are kept confidential.) Forms close the 10th day of the month preceding month of publication. Address all ads Attention: Classified Ad Department, ***The Journal.***

To assure prompt delivery, when replying to an advertisement over a ***Journal*** box number, address letters as follows: Box (insert number), c/o ***The Ohio State Medical Journal***, 600 South High Street, Columbus, Ohio 43215.

PEDIATRICIAN: Solo or associate practice in city of 40,000. Office space, housing, and excellent 250-bed general hospital with privileges available. Contact: Robert Flint, 614/382-8211 (weekdays) or 614/382-3442, MARION GENERAL HOSPITAL, McKinley Park Drive, Marion, Ohio 43302.

GENERAL MEDICAL OFFICES AVAILABLE FOR RENT: In Hartville, reportedly the fastest growing township in Ohio. New construction permitting individual furnishing. Physically attached to Cancer Center with diagnostic x-ray, laboratory, and pharmacy facilities. Contact George N. Swallon Agency, Canton, Ohio, 216/456-3495, or inquire of R. K. Loeffler, M.D., 650 South Prospect, Hartville, Ohio 44632.

ERPG, INC.— OHIO: Seeking two, young, full-time, career-oriented, emergency room physicians. Salary $60,000 per year. Health and malpractice insurances paid. Partnership in two years. Ohio license required. Send complete curriculum vitae to: Metin M. Ercan, M.D., Mercy Medical Center, Springfield, Ohio 45504.

HOUSE PHYSICIANS WANTED: For a community hospital located in northeast Ohio. Housing and uniform allowances provided. Attractive fringe benefits, including insurance. Salary negotiable. Must have current Ohio licensure. Reply Box 813 c/o Ohio State Medical Journal.

INTERNAL MEDICINE: Excellent practice, now solo, needs to add an IM physician. Board-qualified mandatory. Excellent community and hospital. Contact Robert Flint, MARION GENERAL HOSPITAL, Marion, Ohio 43302 or phone: 614/382-8211 or 382-3442.

GENERAL PRACTITIONER WANTED: To join multispecialty group practice in Northeastern Ohio. Present group consists of two surgeons, two internists, and two general practitioners. General practice limited primarily to adult medicine. No surgery or obstetrics required. For further information call collect or write: Glenn E. Eippert, M.D., or Richard S. Millberg, M.D., 430 West 25th St., Ashtabula, Ohio 44004. Phone: 216/998-1212.

AMBULATORY CARE CENTER — EMERGENCY DEPARTMENT STAFF PHYSICIAN, ATHENS, OHIO: 20,000 annual patient visits. Flexible scheduling, minimum guarantee/monthly bonus, excellent fringes. Contact Eric Jenison, M.D., O'Bleness Memorial Hospital, Athens, Ohio 45701, or call toll-free 800/325-3982 for details.

FAMILY PRACTICE — RURAL PRACTICE: Northwest/central rural/agrarian community of 1200/1500 needs family practice physician. Practice could expand to cover 3000/3500 population area. No physician now practicing. Community will support. Major regional hospital within driving distance. Contact ROBERT FLINT, MARION GENERAL HOSPITAL, MARION, OHIO 43302, phone 614/382-8211 or 382-3442.

OBSTETRICIAN-GYNECOLOGIST WANTED: To join well-established corporation in Central-Northwestern Ohio city. First-year salary $40,000; with benefits $74,000. Early full membership in corporation. Partner of 25 years retiring. Contact Box 820 c/o Ohio State Medical Journal.

PHYSICIANS

Excellent opportunities exist in Ohio and Pennsylvania. Hospitals, clinics, and solo practice in a broad range of medical specialties, ie, Family Practice, Medicine, Radiology, PM&R, Oncology, Psychiatry, Orthopedics, Neurology, Plastic Surgery, Pediatrics, and Emergency Medicine. We can assist you with any one of these opportunities. There are no fees or charges to you. For a confidential inquiry forward curriculum vitae to:

DOCTORS SERVICES, INC.
29525 Chagrin Blvd.
Cleveland, Ohio 44122

(Classified Ads continued on page 196)

SEA, SAND AND SUNSHINE: Tortola, British Virgin Islands. New house for rent to visitors until we retire. Sleeps four. Fully equipped and furnished, 1½ bath, kitchen, washing machine, and phone. Write: Reverend Raynes, 105 W. Princeton, Youngstown, Ohio 44507 or phone 216/782-4536.

ORTHOPEDIST WANTED: By well-established, 41-physician, multi-specialty group in Ohio. Major regional medical center including four rheumatologists. Should be board certified or eligible. Please enclose current curriculum vitae with reply to Box 824 c/o Ohio State Medical Journal.

EMERGENCY PHYSICIAN DIRECTORS: Needed in Ohio and Pennsylvania. Remuneration is a percentage of gross receipts of emergency department. Malpractice insurance paid plus excellent fringes. Regional directorship openings in near future. Ohio and/or Pennsylvania license required. Forward curriculum vitae to Doctors Services, Inc., 29525 Chagrin Blvd., Cleveland, Ohio 44122.

MARION, OHIO: Excellent opportunities in Central Ohio. Existing and new, solo, partnerships, or association practices available and seeking physician support. Top compensation— reliable cross coverage. Exceptionally attractive, 250-bed, well-equipped regional medical center hospital within walking distance from offices. Industry and agriculture support city/45,000; county/65,000; and total trade area/250,000. Excellent schools and residential areas. Fifty-minute, easy drive to Columbus. Active need for—

FAMILY PRACTICE
INTERNAL MEDICINE
OTOLARYNGOLOGY
PEDIATRICS
ORTHOPEDIC SURGERY
EMERGENCY MEDICINE
GENERAL SURGERY

We are seeking either rural or city-oriented physicians. Send C.V. or contact— ROBERT FLINT, Marion General Hospital, MARION, OHIO 43302 — or call 614/382-8211 or 382-3442 any time.

FAMILY PRACTICE: Existing general practices need new partners or associates. Top medical community. Excellent general hospital. Offices and cross coverage available. Contact: ROBERT FLINT, Marion General Hospital, MARION, OHIO 43302, telephone: 614/382-8211 or 382-3442 any time.

JULY STAFF EMERGENCY DEPARTMENT OPENING: Zanesville, Ohio. A 500-bed modern hospital with excellent backup. Flexible scheduling. Minimum guarantee/fee-for-service income $50,000-$70,000. Only 50 miles from Ohio State University, great recreational area. Send curriculum vitae to Howard Marsh, M.D., Director of Emergency Services, Good Samaritan Medical Center, 800 Forest Avenue, Zanesville, Ohio 43701, or call Toll Free 800/325-3982, Ext. 220.

EXCELLENT FEE-FOR-SERVICE INCOME: Athens, Ohio. Salary $50,000-$70,000 per year plus. Rapidly expanding emergency department with growth potential. Flexible scheduling. Outstanding university town, home of Ohio University, located in the rolling foothills of southern Ohio. Send curriculum vitae to Eric Jenison, M.D., Director of Emergency Services, O'Bleness Memorial Hospital, Athens, Ohio 45701, or call Toll Free 800/325-3982, Ext. 220.

GENERAL SURGERY: Established general surgery partnership has too much to handle, must expand, add third physician. New facility. Excellent hospital within walking distance. Contact Robert Flint, 614/382-8211 (weekdays) or 614/382-3442, MARION GENERAL HOSPITAL, McKinley Park Drive, Marion, Ohio 43302.

MEDICAL DIRECTOR AND STAFF PHYSICIANS: County-owned-and-operated, long-term facility with skilled nursing, tuberculosis, pediatric, chronic illness, alcoholism detox, and rehab divisions. Full-time positions available immediately in 199-bed, JCAH-approved facility. Ohio license required. Salary negotiable. For further information write to: Kathryn E. Shearer, Assistant Administrator, Molly Stark Hospital, Box 9122, Canton, Ohio 44711, phone: 216/875-5531.

FOR SALE: Modern medical office building, Warren, Ohio. One floor, 4,200 sq. ft., 30 parking spaces. Excellent location one block from hospital. Air conditioned. Excellent for any profession or business. Serious inquiries only to 1621 E. Market St., Warren, Ohio 44483, phone: 216/393-2583.

SEEKING: Two general physicians, internists. Established practice in North-Central Ohio. Modern professional building. Corporate advantages. Reply Box 822 c/o Ohio State Medical Journal.

INTERNIST WANTED: Need additional internal medicine physician. Board qualified. Established group practice in Lakewood, Ohio. Excellent salary. Fringe benefits with full membership in group within one year. Reply Box 815, c/o Ohio State Medical Journal.

FOR SALE OR LEASE: Large doctor's office, 5,000 sq. ft. X-ray equipment. 328 E. State Street, Columbus, Ohio, across from Grant Hospital. Phone: 614/258-5644.

HOUSE PHYSICIANS IN MEDICINE: M.D. or D.O. needed for hospital in Southeast Ohio. No weekend duty, excellent compensation, 17 weeks off annually. Paid malpractice insurance plus other benefits. Ohio license required. Contact Doctors Services, Inc., 29525 Chagrin Blvd., Cleveland, Ohio 44122, phone: 216/292-7445.

SITUATIONS WANTED: Obstetrician/gynecologist and surgeon. Wife and husband both board eligible. No preference as to type of practice or location. Available July 1978. Reply Box 823 c/o Ohio State Medical Journal or call 212/254-1329, evenings and nights.

WILDERNESS SITE FOR SALE: Secluded, recreational retreat. Heavily wooded 95 acres. Horse trails, fishing, excellent hunting— bird and game. Remote, but good roads. Ideal for lodge or camp-site for individual or group ownership. Near Hillsboro, 90 minutes from Dayton, Columbus, and Cincinnati. Write: Phil Dobert, M.D., 6296 State Road 753, Route 4, Hillsboro, Ohio 45133.

IMMKE CIRCLE LEASING INC

Endorsed Leasing Company
Of The Ohio State Medical Association

Immediate delivery on many 1978 models

We lease all foreign and domestic makes and models
including Mercedes, Jaguar, Porsche, etc.

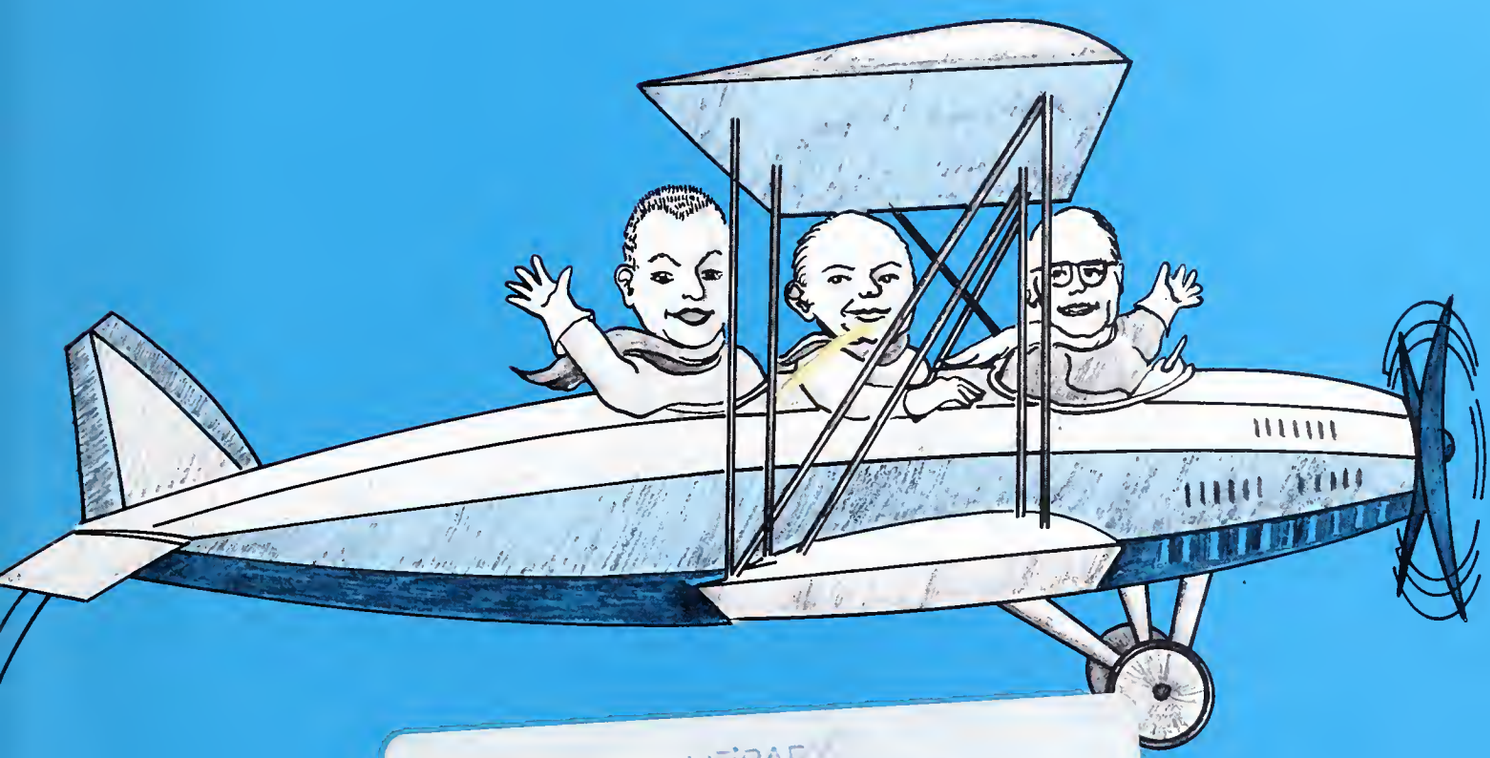
Many people think of leasing as just automobiles.
We do that too, but, in addition, we want to lease you any professional equipment.

Immke Circle Leasing, Inc.
32 South Fifth Street
Columbus, Ohio 43215

Telephone 614-228-1701 or Toll Free 1-800-282-0256

APRIL 1978
Volume 74, Number 4

THE OHIO STATE Medical Journal



LIBRARY
U.C. SAN FRANCISCO
APR 27 19

CoME to Dayton May 6-10, 1978

PUBLISHED BY THE OHIO

THE LIBRARY
ACQUISITIONS DIVISION
UNIVERSITY OF CALIFORNIA, SAN FRAN
SAN FRANCISCO, CALIFOR.IA 94143

N



THE STRENGTH TO OVERCOME EXCESSIVE ANXIETY IN THE ELDERLY CARDIAC PATIENT.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

VALIUM®
(diazepam) IV

2-MG TABLETS B.I.D. OR T.I.D.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Legislative Update

the state scene

(Courtesy the OSMA Department of State Legislation)

House Passes Venereal Disease Test Revision 87-0

HB 687 (Batchleder, R-Medina), as amended by the House Health and Retirement Committee, will change the time of the gonorrhea test from the first visit to the first 60 days of the last trimester as determined by the physician. The revision means that the test will be given closer to the time of the child's birth. HB 687 improves the present law by reducing the time between the gonorrhea test and the child's birth and thereby reduces the possibility of reinfection. Although the OSMA opposes the statutory mandating of any medical procedure because the decision of whether or not a procedure is necessary or appropriate is a medical one, the bill does improve the current law and was supported by the OSMA.

House Approves Department of Health Finance and Planning Bill

By a vote of 73 to 20, the Ohio House approved HB 490 (Christman, D-Englewood), creating a new cabinet-level Department of Health Finance and Planning. The new agency would be responsible for the administration of health planning and Ohio's Medicaid program. The Department of Health, presently the State's designated planning agency, is stripped of its health-planning duties; and the Department of Public Welfare will no longer administer the Medicaid program. In addition, the new agency will review and comment upon all health matters (including Blue Cross rate filings) before the Department of Insurance.

During a brief floor debate, Rep. Christman called HB 490 "an effort to provide coordination of Ohio's health care programs." He stated that the measure would give the General Assembly a better handle on the administration of the health care programs operated in Ohio. Rep. Alan Norris (R-Westerville) was the single opponent in the short floor debate. He stated that Ohio did not need a new department that would saddle the taxpayers with the cost of a new bureaucracy. The sponsor countered that the new structure would be more efficient than the ones it was replacing. The bill moves to the Senate for further consideration.

Helmet Law Repealed

After sitting in the Senate Rules Committee for eight months, HB 115 was scheduled for vote by the Ohio Senate last week. After extensive debate centering upon the issue of the motorcycle rider's freedom of choice, the Senate repealed Ohio's motorcycle helmet law. OSMA opposition to the repeal of the helmet law was cited by Sen. Michael J. Maloney (R-Cincinnati) during the debate. Sen. Maloney discussed several medical studies on the importance of a helmet in an accident. However, the Senator's arguments failed to carry the day, and the legislation passed 18-14. After House concurrence in Senate amendments, the bill was sent to the Governor for his signature. The OSMA continues to oppose enactment of this legislation.

Health Care Delivery Hearings

The House Committee on Health and Retirement is planning a series of statewide hearings to discuss "the problem of making health care accessible and reasonably costed to everyone." More specifically, this legislative committee will be investigating: "(1) The high cost of Blue Cross and what is being done, in light of HB 448 from the 111th General Assembly, to hold down Blue Cross increases; (2) Waste and duplication of services in hospitals; (3) The problem of too many hospital beds; and (4) The provision of quality health-care services to rural and inner-city persons."

The chairman of the committee, John D. Thompson, Jr., (D-Cleveland) hopes that these hearings can serve as a "springboard for legislative action." Although the House Health and Retirement Committee would seem to have original jurisdiction over these health issues this year, most of the bills dealing with these issues have been referred to the House and Senate Finance Committees. The Chairman has expressed his desire to better understand the current problems in the delivery of health care. Hearings are tentatively scheduled as follows: April 7— Portsmouth (SE Ohio), April 21— Cincinnati, May 5— Toledo, May 19— Cleveland. Physicians interested in responding to these or other issues of health care delivery should attend these meetings.

Dept. of Health's Radiation Control Program Receives Hearing

The House Energy and Environment Committee held its first hearing on House Bill 1075 (Eckart, D-Euclid). The bill will significantly expand the Ohio Department of Health's "radiation control program." The bill permits the Department to **license, inspect** and **enforce** its regulation on all **medical** and **non-medical** "radiation sources."

In a Subcommittee hearing, the OSMA was represented by N. Ray Baumgartner, M.D., George Calendine, Ph.D., and the Department of State Legislation. The Subcommittee and Rep. Eckart agreed with the OSMA position that the Department of Health should accept those inspections that are presently being done effectively. The elimination of duplication in the inspection process and the inclusion of physician specialists on the Governor's Advisory Commission were the two major recommendations of the OSMA.



the federal scene

(Courtesy the OSMA Department of Federal Legislation and the AMA Washington Office)

Study Released on Health Care Insurance Protection

A study released recently indicates that 94% of the American public have some sort of health care protection and that 6%, or some 12.2 million people, have none at all. Most of those with no protection whatever are among the so-called "working poor." The findings are the results of 18 months of work by an independent research team to determine how many people are in the unprotected category and who they are. For the purpose of the study, *coverage* was defined as "protection against the expenses of hospitalization and in-hospital physician care."

In *National Health Insurance Issues: The Unprotected Population,* Washington-based researchers Stephen G. Sudovar, Jr., and Kathleen Sullivan reveal that the number of Americans in the "gap" between private insurance coverage and public assistance is much lower than has been widely believed. A recent Congressional Budget Office estimate put the unprotected figure at 18 million persons, while other estimates have ranged as high as 40 million. The authors' National Health Insurance (NHI) "gaps" study is being distributed nationally to key state and federal legislators as well as to health-care administrators, researchers, planners, and policymakers.

According to the authors, overlapping and sometimes incomplete counts by various agencies have long been an obstacle to accuracy in estimating the U.S. gap. Over the past year and a half, using official data from federal and state agencies and insurance industry sources, followed up by field interviews with government and industry spokesmen, Sullivan and Sudovar subtracted out people listed as being covered by more than one plan or institution in 1975. They then checked the total against the corresponding year's population estimate.

Their efforts indicate that 150.5 million Americans are covered through private insurance plans; 37.5 million are enrolled in Medicare and Medicaid; and the remaining 10.3 million receive care through either the Armed Forces, state and federal prison systems, Indian health programs, or other government institutional membership.

The study relates that for the most part, people in the gap are those who are unemployed, under-employed, self-employed, or in such poor health to begin with that they are virtually uninsurable. Half of them— almost 7 million— earn less than $10,000 a year per family. In short, they are not poor enough to qualify for Medicaid, old enough to apply for Medicare, or financially able or healthy enough to buy private coverage on their own, the study says.

According to the authors, the first step in any national health policy should be toward providing coverage for those 12.2 million Americans who find themselves totally unprotected. Sudovar and Sullivan point out that the present financing system of public assistance augmenting private insurance in the United States is working for 94% of the population, or some 200 million people. The remaining 6% ". . . are the people who need health insurance coverage the most and who should be given the highest-priority attention by health policymakers," Sudovar said in an interview.

"They are the very same people, because they have absolutely no protection for hospitalization or in-hospital physician costs, who can be financially wiped out by a single accident or a sudden illness."

Rather than scrap the existing system for one that would simply duplicate the coverage that most people already have, Sudovar suggests that National Health Insurance, as a first step, should aim at providing at least these basic minimums to those in the so-called coverage "gap."

Copies of *National Health Insurance Issues: The Unprotected Population* may be obtained by writing Ben Kubasik, Inc., 25 West 43rd Street, New York, New York 10036.

Journal Advertisers

Breon Laboratories, Inc. 263, 264
Brown Pharmaceutical Company, Inc. 202, 260, 261
Burroughs Wellcome Co. 200, 265, 272, 273
Daneman Laboratories 240
Harding Hospital 250
Immke Circle Leasing 250
Lilly, Eli and Company 214
Mead Johnson 243, 244, 245, 246
Medical Protective Company 221
Medical World News 267
Menendian Carpets 213
Merck Sharp & Dohme 268, 269
Microtech, Inc. 225
Ohio Medical Indemnity 262
OSMA Annual Meeting 215, 216, 217, 218, 239
Pennwalt Prescription Products 222, 223
Pharmaceutical Manufacturers Association 258, 259
Physicians Insurance Company of Ohio 210
Practice Productivity, Inc. 253
Roche Laboratories, Div. of Hoffmann-LaRoche, Inc. ..... 276, 277, 278, Cover 2, Cover 3, Cover 4
Smith, Kline and French 226, 227
Turner and Shepard, Inc. 251
United States Air Force 228
United States Navy 271
Upjohn Company 249
Warren-Teed Laboratories 219, 255
Wendt-Bristol Company 242
Windsor Hospital 203

OSMA OFFICERS
President
WILLIAM M. WELLS, M.D.
211 Hudson Avenue
Newark 43055
President-Elect
JOHN J. GAUGHAN, M.D.
7911 Detroit Avenue
Cleveland 44102
Past President
GEORGE N. BATES, M.D.
2102 Shenandoah Road
Toledo 43607
Secretary-Treasurer
ROBERT G. THOMAS, M.D.
630 East River Street
Elyria 44035

EDITORIAL STAFF
Consulting Medical Editor
RICHARD L. MEILING, M.D.
Managing Editor and Business Mgr.
HART F. PAGE
Executive Editor and Executive Business Manager
LINDA A. PORTERFIELD
Editorial Assistant
MARY LOU BRADY
Communications Editor
REBECCA J. DOLL
Continuing Medical Education Editor
GAIL E. DODSON
Ass't. Continuing Medical Education Editor
DAVID C. TORRENS
Federal Legislation Editor
CHARLES W. EDGAR
Field Service Editor
ROBERT E. HOLCOMB
Government Relations Editor
HERBERT E. GILLEN
Health Education Editor
ROBERT D. CLINGER
Membership Editor
KATHERINE E. WISSE
Organization Services Editor
JERRY J. CAMPBELL
State Legislation Editor
D. BRENT MULGREW, ESQ.
Ass't. State Legislation Editor
RICHARD A. AYISH

Address All Correspondence, Address Change, & Reprint Request (unless otherwise, noted):
Executive Editor
The Ohio State Medical Journal
600 South High Street
Columbus, Ohio 43215
Phone: 614/228-6971

Published monthly under the direction of The Council for and by members of The Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215, a scientific society, nonprofit organization, with a definite membership for scientific and educational purposes.

1977 Subscription: $10 per year, single copy $1.50 (outside U.S. $13 and $2).

Entered as second class matter July 5, 1905, at the Post Office at Athens, Ohio, under the Act of Congress of March 3, 1879. Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918. Second-Class Postage Paid at Athens, Ohio.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertisers must conform to policies and regulations established by The Council of the Ohio State Medical Association.

Publication office: 900 East State Street, Athens, Ohio 45701.

Printed by
The Lawhead Press, Inc., Athens, Ohio

VOL. 74 APRIL 1978 NO. 4

THE OHIO STATE Medical Journal

Clinical and Scientific Articles

CANCER EDUCATION SERIES: MALIGNANT MELANOMA 254
Charles D. Cobau, M.D., and Ranieri Rocchi, M.D., Toledo

Preliminary Program for 1978 OSMA Annual Meeting

ALL ROADS LEAD TO DAYTON 201
ANNUAL MEETING FORMAT 203
1978 CANDIDATES FOR THE OFFICE OF OSMA PRESIDENT-ELECT 206
DELEGATE AND ALTERNATE SCHEDULE 208
MEAL FUNCTIONS 209
MEMBERS OF THE 1978 HOUSE OF DELEGATES 211
PHYSICIANS' ART SHOW 215
OSMA SOCIAL FUNCTION IN HONOR OF AMA PRESIDENT AND MRS. JOHN H. BUDD 216
OMPAC PRESENTS WASHINGTON COLUMNIST, ROBERT D. NOVAK 217
ANNUAL MEETING REGISTRATION FORM 218
RESOLUTIONS FOR THE 1978 HOUSE OF DELEGATES 220
CONTINUING MEDICAL EDUCATION COURSES
Postgraduate Courses 229
Special Interest Programs 230
Specialty Section Programs 231
Tours 237
WHAT TO SEE AND WHERE TO EAT IN DAYTON 238
Mrs. W. J. Marshall, Montgomery County Medical Auxiliary

Special Articles

SUPPORT OSMA . . . PAY YOUR 1978 DUES 237, 266
COUNTY SOCIETY OFFICERS, EXECUTIVE DIRECTORS, AND MEETING DATES 247
AUXILIARY INVOLVEMENT IN IMMUNIZATION CAMPAIGN 256
Mrs. Albert May, President, OSMA Auxiliary

Features

Legislative Update — State 197
Legislative Update — Federal . . . 198
Journal Advertisers 198
New Members 257
News 260
Colleagues in the News 262
Continuing Education Programs . . 265
Obituaries 266
Proceedings of the Council 270
Letters to the Editor 275
Classified Ads 279

THREE-IN-ONE THERAPY AGAINST TOPICAL INFECTION



Neosporin® Ointment

(Polymyxin B-Bacitracin-Neomycin)

This potent broad-spectrum antibacterial provides overlapping action to help combat infection caused by common susceptible pathogens (including staph and strep). The petrolatum base is gently occlusive, protective and enhances spreading.

Neomycin

Staphylococcus
Haemophilus
Klebsiella
Aerobacter
Escherichia
Proteus
Corynebacterium
Streptococcus
Pneumococcus

Bacitracin

Staphylococcus
Corynebacterium
Streptococcus
Pneumococcus

Polymyxin B

Pseudomonas
Haemophilus
Klebsiella
Aerobacter
Escherichia

In vitro overlapping antibacterial action of Neosporin® Ointment (polymyxin B-bacitracin-neomycin).

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Neosporin® Ointment

(Polymyxin B-Bacitracin-Neomycin)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

All Roads Lead to Dayton

1978 OSMA Annual Meeting

This preliminary program is designed to acquaint physicians with 1978 Annual Meeting activities prior to meeting time. Read it carefully. Plan your days with deliberation. Take advantage of the many continuing medical education course offerings.

Fee Courses

Preregistration for courses involving fees is desirable. Such registration also applies to social activities. The OSMA Department of Continuing Medical Education will mail tickets to all individuals whose registration form and fees are received by April 25. All other tickets may be picked up at the OSMA Registration Desk.

Anyone who has not preregistered for courses prior to meeting time should check at the ticket sales desk concerning the availability of courses.

Please note that the Basic Life Support program is being offered on Friday afternoon, May 5, from 1-6 PM. This course is a prerequisite for Advanced Life Support, May 6.

Other Courses

Specialty society programs are open to anyone registered for the meeting. Many of these programs have been designated Category I.

Two new offerings are the Pfizer Dialogue Programs and the OSMA Legislative Update. The Pfizer courses will occur on Tuesday, May 9, with each offering being one hour in length. Physicians may earn one hour Category I credit for each course attended.

The OSMA Legislative Update is a face-to-face discussion of Ohio legislation which takes up where the "Legislative Update" (published in *The Ohio State Medical Journal)* and the "Legislative Bulletin" leave off. Both of these publications come from the OSMA Department of State Legislation. OSMA members and members of the OSMA Auxiliary are encouraged to attend. Medical service tomorrow could well depend on legislation being considered today.

Special Events

Tuesday, May 9, will be a special day in the lives of AMA President and Mrs. John H. Budd, Cleveland. The OSMA and the OSMA Auxiliary are joining together to sponsor a social function in honor of this couple. The evening will feature cocktails and dinner at Wright State University, followed by a university production of the musical *Cabaret*. Tickets are $20 per person and may be purchased by completing the 1978 Annual Meeting Registration Form.

Another special event is the OMPAC Luncheon. An annual event, this luncheon brings together physicians, spouses, and legislators to hear a speaker discuss the current political scene. This year's speaker is Robert D. Novak, Washington columnist and a popular repeat from previous OMPAC luncheons. Use the Registration Form to register for this event at $10 per person.

Bus tours are planned to numerous Dayton attractions. One such tour will cover medical facilities in the area. In addition, tours are available to the U.S. Air Force Museum and Wright State University School of Medicine.

Hospitality Center

The Montgomery County Medical Society will provide continuous assistance to visitors to Dayton through their Hospitality Center. The Center will be in the Dayton Exhibition Center.

Art Show and Photography Exhibit

Under the direction of Ludolph H. van der Hoeven, M.D., Dayton, a Physicians' Art Show will be displayed and judged during the course of the 1978 Annual Meeting. Physicians and their spouses should use the Art Show Application Form to enter their creative works. This show and *The Ohio State Medical Journal* Photographic Exhibit will be displayed in the Dayton Convention Center. Awards will be presented at the second session of the OSMA House of Delegates.

Montgomery County Glee Club Concert

Back by popular demand, the Montgomery County Glee Club will again perform at Annual Meeting. This group is composed entirely of physicians and is directed by OSMA Councilor W. J. Lewis, M.D., Dayton. Their performances have been hits at local events as well as AMA national meetings. The glee club will sing following the close of the first session of the OSMA House of Delegates.

New OSMA Membership Service to Be Presented

The OSMA, through the OSMA Task Force on Professional Liability, is pleased to invite you to view a new membership service called Medical Patient Risks Education Program (MED PREP). Prepared by the Colorado firm Jeppesen Sanderson, MED PREP is designed to minimize the possibility of a patient initiating a malpractice suit through comprehensive and documented patient education.

The program consists of films which are 10-15 minutes in length. Each film explains, in a straight-forward-yet-personal fashion, the basic anatomy involved in the procedure, the treatment indicated, and the significant potential risks. Alternative methods of treatment are also discussed when appropriate.

Mr. Robert J. Stephenson, District Salesmanager of Jeppesen Sanderson, will be present to conduct demonstrations and to answer questions. The booth can be visited on the exhibit floor.

When **impotence** *due to*

androgenic deficiency is driving them apart



Android®-5 Buccal Tabs
Android®-10 Oral Tabs
Android®-25 Oral Tabs

Methyltestosterone U.S.P. – 5, 10, 25 mg.

Additional Indications:

REPLACEMENT THERAPY. When Androgen Deficiency is cause of:

- Male Climacteric
- Eunuchoidism, Eunuchism
- Post-Puberal Cryptorchidism

New Double-Blind Study ANDROID-25 vs. Placebo*

*R. B. Greenblatt, M.D.; R. Witherington, M.D.,; I. B. Sipahioglu, M.D.; Hormones for Improved Sexuality in the Male and Female Climacteric. **Drug Therapy,** Sept. 1976.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the **male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE: Robert B. Greenblatt, M.D.,** and **D. H. Perez, M.D.:** "The Menopausal Syndrome," *Problems of Libido in the Elderly,* pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

BROWN **THE BROWN PHARMACEUTICAL CO., INC.** 2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

Annual Meeting Format

Headquarters Hotel— Stouffers Dayton Plaza
Fifth & Jefferson Streets

Coheadquarters Hotel— Sheraton-Dayton Downtown
21 S. Jefferson Street

Exhibits and Scientific Meetings— Dayton Exhibition Center (DEC)
22 Dave Hall Plaza

Auxiliary— Ramada Inn, Downtown
330 W. First Street

Friday, May 5, 1978

Basic Life Support
1 - 6 PM Rooms 302 - 303, DEC

Saturday, May 6, 1978

Registration
7 AM - 3 PM Main Lobby, DEC

Advanced Life Support
8 AM - 6 PM Rooms 302 - 303, DEC

Art of Negotiations
8 AM - 5 PM Room 204, DEC

Development and Evaluation of A/V Instructional Material
8:30 AM - 5 PM Room 207, DEC

Course on Medical Writing
(Preparation of Scientific Papers for Medical Journals)
1 - 4 PM Rooms 205 - 206, DEC

Ohio Psychiatric Association Council Meeting
4 - 9 PM Meeting, Deeds Room, Sheraton
6 PM Dinner, Patterson Room, Sheraton

American Medical Writers Association— Ohio Valley Chapter
6:30 PM Social Hour, Dayton Room, Sheraton
7:30 PM Dinner, Montgomery Room, Sheraton

Sunday, May 7, 1978

Advanced Life Support
8 AM - 6 PM Rooms 302 and 303, DEC

12 Noon Luncheon, Van Cleve I, Stouffers

Art of Negotiations
8 AM - 4 PM Room 204, DEC

12 Noon Luncheon, Room 202, DEC

Breakout Rooms— 201, 208, 209, 306, 307 and 308 (All DEC)

Development and Evaluation of A/V Instructional Material
8:30 AM - 4 PM Room 207, DEC

Course on Medical Writing
9 - 12 AM Rooms 205 - 206, DEC

Ohio Psychiatric Association and Internal Medicine
9 AM - 3 PM Meeting, Kettering Room, Sheraton

12 Noon Luncheon, Montgomery Room, Sheraton

(continued on next page)



WINDSOR HOSPITAL
A NONPROFIT CORPORATION
— ESTABLISHED 1898 —
Chagrin Falls, Ohio
247 - 5300

A hospital for the treatment of Psychiatric Disorders

High on a Hill-Top, Overlooking Beautiful Chagrin River Valley.

Accredited by Joint Commission on Accreditation of Hospitals.
Booklet available on request.

FRIEDRICH A. LINGL, M.D. Medical Director
GUY H. WILLIAMS, JR., M.D. Medical Director Emeritus
HERBERT A. SIHLER Jr. President

MEMBER: American Hospital Association—National Association of Private Psychiatric Hospitals

Annual Meeting Format *(continued)*

OSMA Delegation to AMA
2 - 4 PM Room 203, DEC

House of Delegates
3 - 7 PM Registration, Main Lobby, DEC

5:30 PM Buffet Dinner: Delegates, Alternates, OSMA Council and Official Guests. Van Cleve Ballrooms, Stouffers

7 - 9 PM First Business Session, Assembly Hall, DEC

Councilor District Caucuses
4 - 5:30 PM

District 1 - Room 202, DEC
District 2 - Room 205, DEC
District 3 - Kettering Room, Sheraton
District 4 - Room 305, DEC
District 5 - Room 301 or VIP Lounge, DEC
District 6 - Room 206, DEC
District 7 - Deeds Room, Sheraton
District 8 - Patterson Room, Sheraton
District 9 - Dayton Room, Sheraton
District 10 - Room 304, DEC
District 11 - Montgomery Room, Sheraton
District 12 - Wright Room, Sheraton

Montgomery County Glee Club (following House of Delegates meeting)
9:30 PM Auditorium, DEC

Monday, May 8, 1978

Reference Committee Hearing Registration
6:30 AM Van Cleve Lobby, Stouffers

Complimentary Buffet Breakfast— Delegates, Alternates, OSMA Council and Official Guests
7 - 8 AM Van Cleve I and II, Stouffers

Reference Committee Hearings
7:30 - 12 - 1:30 PM (additional time if necessary)

Res. Committee 1— Dayton Room, Stouffers
Res. Committee 2— Van Cleve IV, Stouffers
Res. Committee 3— Van Cleve III, Stouffers
President's Address— Room 205, DEC
Nominations— Room 206, DEC

Scheduled Visitation of Dayton Medical Facilities via bus
8 AM Pick-up in front of DEC

General and Advance Registration Opens
8:30 AM - 5 PM DEC

Dermatology
9 AM - 4:30 PM Meeting, Room 204, DEC

Otolaryngology
9 AM - 5 PM Meeting, Room 202, DEC

12 Noon Luncheon, Van Cleve I, Stouffers

Chest Physicians
9 AM - 5:15 PM Meeting, Room 302, DEC

12 Noon Luncheon, Van Cleve II, Stouffers

Ohio Health Commissioners
11 AM - 4 PM Meeting, Regency Room, Sheraton

Exhibits Open
12 Noon - 4:30 PM DEC

Cultural Show
12 Noon - 4:30 PM DEC

Rheumatology
12 Noon Luncheon, Patterson Room, Sheraton

1:30 - 5 PM Meeting, Room 207, DEC

Physical Medicine and Rehabilitation
1:30 - 4:30 PM Meeting, Room 203, DEC

Legislative Program
1:30 - 3 PM Assembly Hall, DEC

Reception for Exhibitors
5 - 6 PM Room 301 (VIP Lounge), DEC

OMI Reception
5 - 6:30 PM Van Cleve I, Stouffers

Jefferson Medical College Reception
6 PM Van Cleve II, Stouffers

Medical Mutual Reception
9 PM Van Cleve I, Stouffers

Tuesday, May 9, 1978

Registration Desk for Postgraduate Courses
6:30 AM - (open) Sheraton

Postgraduate Courses
(continued on Wednesday— same time and rooms)

7:30 - 9:30 AM
Course 1: Electrolytes and Blood Gases— David P. Nicholson, M.D., Montgomery Room, Sheraton

Course 2: Therapeutic Logic in Common Drug Interactions— John Lindower, M.D., Dayton Room, Sheraton

Course 3: How to Deal with Alcoholic Patients in Practice— Abraham Heller, M.D., Patterson Room, Sheraton

Course 4: Pediatric Emergencies— Charles H. Wharton, M.D., Wright Room, Sheraton

Course 5: Death and Dying— Roger D. Blackwell, Ph.D., Kettering Room, Sheraton

Room for continental breakfast for all 5 courses— Deeds Room, Sheraton

OMPAC Board Breakfast
8 - 11 AM Plaza XIV, Stouffers

County Medical Society Executives Breakfast
8 - 11 AM Van Cleve III, Stouffers

Ophthalmology
8 AM Breakfast, Dayton Room, Stouffers

10 AM - 4:30 PM Meeting, Room 302, DEC

12 Noon Luncheon, Dayton Room, Stouffers

General and Advance Registration
8:30 AM - 4:30 PM DEC

Sports Medicine and Family Practice
9 AM - 12 Noon Meeting, Room 303, DEC

12 Noon Luncheon, Wright Room, Sheraton

Exhibits
9 AM - 4:30 PM DEC

Internal Medicine
9 AM - 12 Noon Meeting, Room 202, DEC

Pathology
9 AM - 4:30 PM Meeting, Room 203, DEC

Ohio Health Commissioners
9 AM - 4 PM Meeting, Regency Room, Sheraton

Pfizer Dialogue Presentations
(Tuesday only)
9 - 10 AM P1: Stress and Depression, Exhibit Floor, DEC

11 AM - 12 Noon P2: Use of Major Tranquilizers in Office Practice, Exhibit Floor, DEC

1 - 2 PM P3: Problems in Diabetic Management, Exhibit Floor, DEC

3 - 4 PM P4: Management of the Hypertensive Patient, Exhibit Floor, DEC

Neurosurgery
9 AM - 5 PM Meeting, Room 304 and 305, DEC

12:30 PM Luncheon, King Cole Restaurant, Winters National Bank Building, Main and Second Streets

OMPAC Luncheon
11:30 AM - 1:30 PM Reception, Van Cleve III and IV, Stouffers

11:30 AM - 1:30 PM Luncheon, Van Cleve I and II, Stouffers

Emergency Medicine, Ohio Committee on Trauma and Directors of Medical Education
12 Noon Luncheon, Patterson Room, Sheraton

1:30 - 4:30 PM Meeting, Room 204, DEC

Section on General Practice
1:30 - 2:30 PM Meeting, Room 303, DEC

Dinner and Theatre at Wright State University
6:15 PM - Midnight Wright State

Wednesday, May 10, 1978

Postgraduate Courses
7:30 - 9:30 AM

Course 1: Electrolytes and Blood Gases— David P. Nicholson, M.D., Montgomery Room, Sheraton

Course 2: Therapeutic Logic in Common Drug Interactions— John Lindower, M.D., Dayton Room, Sheraton

Course 3: How to Deal with Alcoholic Patients in Practice— Abraham Heller, M.D., Patterson Room, Sheraton

Course 4: Pediatric Emergencies— Charles H. Wharton, M.D., Wright Room, Sheraton

Course 5: Death and Dying— Roger D. Blackwell, Ph.D., Kettering Room, Sheraton

Continental Breakfast— Deeds Room, Sheraton

General and Advance Registration
8:30 AM - 4:30 PM DEC

Ohio Health Commissioners
9 AM - 4 PM Regency Room, Sheraton

Plastic Surgery
9 AM - 12 Noon Meeting, Room 202, DEC

12:15 PM Luncheon, Dayton Room, Sheraton

Allergy and Immunolgy
8:30 AM - 12:15 PM Meeting, Room 203, DEC

12:30 PM Luncheon, Montgomery Room, Sheraton

Exhibits
9 AM - 12 Noon DEC

Committee on Scientific Work
12 Noon Meeting, Plaza XIV, Stouffers

Anesthesiology
1:30 - 4:30 PM Meeting, Room 202, DEC

Colon and Rectal Surgery
12 Noon Luncheon, Patterson Room, Sheraton

1:30 - 4:30 PM Meeting, Room 204, DEC

Radiology
2 - 4 PM Meeting, Room 304 and 305, DEC

House of Delegates
2:30 - 3:30 PM Registration, Main Lobby, DEC

3:30 - 6 PM Final Business Session, Assembly Hall, DEC

6 - 6:45 PM Buffet Dinner: Delegates, Alternates, OSMA Council and Official Guests. Van Cleve Ballrooms, Stouffers

6:45 - 10 PM Final Business Session, Assembly Hall, DEC

Thursday, May 11, 1978

Council Meeting Breakfast
8 - 10 AM Dayton Room, Stouffers

1978 Candidates for the Office of OSMA President-Elect

Sol Maggied, M.D.

Sol Maggied, M.D., family practitioner in West Jefferson, has been nominated for the office of President-Elect of the Ohio State Medical Association. His name was placed in nomination by Doctors Richard F. Slager and Harry J. Shaver, members of the OSMA, who wrote the following letter:



Sol Maggied, M.D.

RICHARD F. SLAGER, M.D., INC
1300 DUBLIN ROAD
COLUMBUS, OHIO 43215

TELEPHONE: 614/488-1818 ORTHOPAEDIC SURGERY

January 30, 1978

Hart F. Page, Executive Director
Ohio State Medical Association
600 South High St.
Columbus, Ohio 43215

Dear Mr. Page:

As a member of the Ohio State Medical Association, I feel that those who have worked long and faithfully for OSMA should have the opportunity to seek high office.

One member who has given unselfishly of himself for the good of the order over at least two decades is Sol Maggied, M.D. This unique physician not only has served as the Madison County delegate to the OSMA House of Delegates, but has also served actively on several OSMA Committees during these decades. OSMA has been and is at the top of Dr. Maggied's priorities in the political, scientific and altruistic arenas.

With this foremost in my thinking, I would like to submit the name of Sol Maggied, M.D. for nomination as president-elect of the Ohio State Medical Association. It is my understanding that the ByLaws require this nomination to be submitted at least sixty days prior to the meeting of the House of Delegates. I am pleased and proud to do so.

Sincerely,

Richard F. Slager

Richard F. Slager, M.D.

RFS:mcw

Harry J. Shaver, M.D.

Dr. Maggied received both his undergraduate and medical degrees from The Ohio State University and served his internship at St. Francis Hospital, Columbus. Following that year, he went on active duty with the United States Navy as a lieutenant in the Medical Corps. Dr. Maggied spent three years as division medical officer of a destroyer escort division and nine months as head of the dispensary unit at St. Albans, New York. After his discharge from the Navy, he set up practice in West Jefferson.

Clinical Instructor in Family Practice at The Ohio State University College of Medicine, Dr. Maggied is on the attending staffs of Mt. Carmel and Grant Hospitals, Columbus, and Madison County Hospital, London. Currently, he is staff secretary-treasurer at Madison County Hospital. He is also a member of the courtesy staff at Children's Hospital, Columbus.

An active member of organized medicine, Dr. Maggied has been a member of the Madison County Medical Society since 1946, having served as president, vice-president, and secretary-treasurer on several occasions. He is now holding office as secretary-treasurer.

On the state level, he has been a delegate to the OSMA House of Delegates from Madison County since 1947. In addition, Dr. Maggied has been a member of the OSMA Committee on Sports Medicine since its inception and has served as chairman of the committee for six years. Dr. Maggied has also given his time to several other OSMA committees including eight years on the Committee on School Health, three years on the Committee on Health Distribution, and many tours of duty on OSMA reference committees.

In addition, Dr. Maggied is a member of the Ohio Academy of Family Physicians, serving as a delegate for 15 years. He is also a member of the board of trustees of this organization.

Nationally, Dr. Maggied is a member of the American Medical Association and the American Academy of Family Physicians. He also belongs to the Medical Unit of the Aladdin Shrine Temple and has been counted among the American Legion ranks since 1946.

However, Dr. Maggied's first love is sports. He is a board member of Varsity O at The Ohio State University, medical advisor to the Football Rules Committee of the Ohio High School Association, and medical coordinator for tournaments of the Ohio High School Athletic Association and for the Central Ohio High School basketball tournaments.

Dr. Maggied has three children. His wife, the former Mary Virginia Smith, died in 1963.

Thomas W. Morgan, M.D.

Thomas W. Morgan, M.D., Gallipolis surgeon, has been nominated for the office of President-Elect of the Ohio State Medical Association. Dr. Morgan was nominated by the Gallia County Medical Society. On behalf of the Society, Doctors Richard G. Patterson and Thomas P. Price wrote:



Thomas W. Morgan, M.D.

GALLIA COUNTY MEDICAL SOCIETY

GALLIPOLIS, OHIO

July 26, 1977

Mr. Hart F. Page
Executive Director
Ohio State Medical Association
600 South High Street
Columbus, Ohio 43215

Dear Mr. Page:

By constitutional privilege, we are pleased to nominate Thomas W. Morgan, M.D., the Ninth District Councilor, as a candidate for the office of President-Elect of the Ohio State Medical Association.

Doctor Thomas W. Morgan is qualified by membership in good standing in the Gallia County Medical Society, the Ohio State Medical Association, and the American Medical Association.

Respectfully submitted,

Richard G. Patterson, M.D.
President

Thomas P. Price, M.D.
Delegate

Dr. Morgan received his undergraduate degree from Washington and Jefferson College and his medical degree from Harvard Medical School. He completed his internship at Peter Bent Brigham Hospital, Boston, and his residency at The Ohio State University Hospital. Dr. Morgan also served as Post Surgeon at the Army War College, Washington, D.C.

A member of the Holzer Medical Center staff since 1952, Dr. Morgan is Chairman of the Department of Surgery and a member of the Board of Trustees of the Holzer Hospital Foundation. He is certified by the American Board of Surgery and is a Fellow of the American College of Surgeons.

Currently completing six years as OSMA Ninth District Councilor, Dr. Morgan has been active in many areas of organized medicine. He is a past president of the Gallia County Medical Society and, subsequently, served as delegate to the OSMA House of Delegates for many years. In addition to his councilor duties on the state level, Dr. Morgan donated his time to the Auditing and Appropriations Committee and the Legislative Committee and chaired the Council Medical Services Review Committee and the Committee on Nominations.

He is presently completing his second term as a member of the Board of Governors of the American College of Surgeons and serves as a member of the Governors Committee on Financial Affairs of the College. Dr. Morgan was appointed to two terms on the Committee on Trauma of the College, where he has recently completed four years as chairman of the Subcommittee on Hospital Emergency Service.

In 1969, Dr. Morgan held the office of President of the Ohio Chapter of the American College of Surgeons. He was elected to active Fellowship in the American Association for the Surgery of Trauma in 1975. In addition, he is a founding member of the American Trauma Society.

Most recently, Dr. Morgan was honored by the Southeastern Ohio Regional Council at its 10th Annual Awards Dinner as one of Southeastern Ohio's outstanding men. He was honored for his contributions to the development of medical services in Southeastern Ohio and his leadership in community affairs. Dr. Morgan was one of the founders of the Ohio Valley Health Services Foundation and continues to serve that organization as vice-president.

Dr. Morgan and his wife, Deanna, are the parents of two sons and three daughters.

Delegate and Alternate Schedule

Sunday, May 7

3 - 7 PM — **Registration for OSMA House of Delegates**
Main Lobby, Dayton Exhibition Center

4 PM

District 1 — Room 202, Dayton Exhibition Center
District 2 — Room 205, Dayton Exhibition Center
District 3 — Kettering Room, Sheraton
District 4 — Room 305, Dayton Exhibition Center
District 5 — Room 301 or VIP Lounge, Dayton Exhibition Center
District 6 — Room 206, Dayton Exhibition Center
District 7 — Deeds Room, Sheraton
District 8 — Patterson Room, Sheraton
District 9 — Dayton Room, Sheraton
District 10 — Room 304, Dayton Exhibition Center
District 11 — Montgomery Room, Sheraton
District 12 — Wright Room, Sheraton

5:30 PM — **Dinner for Delegates, Alternates, OSMA Council and Official Guests**
Van Cleve Ballrooms, Stouffers

7 PM — **Opening Session, OSMA House of Delegates**
Assembly Hall, Dayton Exhibition Center

BUSINESS AGENDA

Call to Order — William M. Wells, M.D., Newark OSMA President

Invocation

Welcome — Herman I. Abromowitz, M.D. President, Montgomery County Medical Society

Report — Committee on Credentials

Consideration of Minutes of 1977 Annual Meeting
(See July 1977 issue of *The Ohio State Medical Journal)*

Consideration of Minutes of 1977 Special Session, December 18, 1977
(See February 1978 issue of *The Ohio State Medical Journal)*

Introduction of AMA Board of Trustees Member

Introduction of Honored Guests

Report — Mrs. Albert May, Marion, OSMA Auxiliary President

AMA-ERF Presentations — Philip B. Hardymon, M.D., Columbus, Chairman, Ohio Committee on AMA-ERF

Presentation of Plaques

To past Councilors, retiring AMA Delegates and Alternates, Chairmen and Members of Standing Committees, and Chairmen of Special Committees.

Announcement — William M. Wells, M.D., Newark

Appointments to the Reference, Credentials, President's Address, Resolutions, and Tellers and Judges of Election Committees.

Elections of Committee on Nominations

Nominations from the floor. One representative (delegate) from each Councilor District. The committee shall report to the second and final session, Wednesday, May 10, 3:30 PM, its recommendations in the form of a ticket containing nominees for offices to be filled at this meeting as required under the Constitution and Bylaws. Under the rotation plan established in 1963, the committeeman from the Fifth District shall serve as Chairman. The report of the Nominating Committee with respect to all offices except President-Elect shall be posted at the registration desk, earliest time practicable and at least three hours before the final session of the House of Delegates.

President's Address — William M. Wells, M.D., Newark

Introduction of Presidents of Other State Societies

Introduction of Resolutions

Resolutions must be introduced at this session of the House of Delegates, referred to the Reference Committees on Resolutions, and reported back to the House of Delegates at the Wednesday afternoon session before any action can be taken.

Miscellaneous Business

Wednesday, May 10

2:30 PM — **Registration for OSMA House of Delegates**
Main Lobby, Dayton Exhibition Center

3:30 PM — **House of Delegates Final Session**
Assembly Hall, Dayton Exhibition Center

6 PM — **Dinner for Delegates, Alternates, OSMA Council, and Official Guests**
Van Cleve Ballrooms, Stouffers

6:45 PM — **Continuation of Final Session**
Assembly Hall, Dayton Exhibition Center

BUSINESS AGENDA

Introduction of Guests

Presentation of Art Awards

Presentation of Journalism Awards

Report of Committee on Credentials

Election of President-Elect

Report of Committee on Nominations and Election of Other Officers

Members of The Council are elected for two-year terms; terms of those representing the odd-numbered districts expire in even-numbered years.

First District: Incumbent, Stewart B. Dunsker, M.D., Cincinnati; Third District: Incumbent, Alford C. Diller, M.D., Convoy; Fifth District: Incumbent, Theodore J. Castele, M.D., Cleveland; Seventh District: Incumbent, Robert E. Rinderknecht, Dover (Note: Ineligible for re-election having served the maximum time on the Council as provided in the Constitution and Bylaws.); Ninth District: Incumbent, Thomas W. Morgan, M.D., Gallipolis (Note: Ineligible for re-election having served the maximum time on the Council as provided in the Constitution and Bylaws.); Eleventh District: Incumbent, S. Baird Pfahl, Jr., M.D., Sandusky.

Election of Delegates and Alternates to the AMA

Four Delegates and four Alternates to be elected for a two-year term starting January 1, 1979, in compliance with the Constitution and Bylaws of the American Medical Association. The following incumbent Delegates and Alternates will serve for the remainder of 1978, their terms expiring December 31, 1978.

Delegates (listed alphabetically): Jerry L. Hammon, M.D., West Milton; H. William Porterfield, M.D., Columbus; Jack Schreiber, M.D., Canfield; Robert N, Smith, M.D., Toledo.

Alternates (listed alphabetically): Dwight L. Becker, M.D., Lima; Thomas E. Fox, M.D., Mason; B. Leslie Huffman, Jr., M.D., Maumee; Robert G. Thomas, M.D., Elyria.

All nominees for the offices of AMA Delegates and AMA Alternates shall run at large. Election of Delegates and Alternates of the AMA shall be governed by Section 7, Chapter 5, of the OSMA Constitution and Bylaws as revised by the House of Delegates in May 1971.

**SPECIAL ORDER OF BUSINESS (after dinner break)
Installation of 1978-1979 Officers

Reports of Reference Committees

President's Address; Resolutions Committee No. 1; Resolutions Committee No. 2; Resolutions Committee No. 3.

Miscellaneous Business

Announcement — John J. Gaughan, M.D., Cleveland, OSMA President

Appointments on Standing Committees and action thereon by the House of Delegates.

Unfinished Business

Adjournment

Meal Functions

Saturday, May 6

Ohio Psychiatric Association: Council Dinner
6 PM, Patterson Room, Sheraton
American Medical Writers Association
Ohio Valley Chapter
Reception: 6:30 PM, Dayton Room Sheraton
Dinner: 7:30 PM, Montgomery Room, Sheraton

Monday, May 8

Luncheons
Otolaryngology
12 Noon, Van Cleve I, Stouffers
Chest Physicians
12 Noon, Van Cleve II, Stouffers
Rheumatology
12 Noon, Patterson Room, Sheraton

Receptions
All Exhibitors
5 PM, Room 301 (VIP Lounge) Dayton Exhibition Center
Ohio Medical Indemnity
5-6:30 PM, Van Cleve I, Stouffers
Jefferson Medical College
6 PM, Van Cleve II, Stouffers
Medical Mutual
9 PM, Van Cleve I, Stouffers

Tuesday, May 9

Breakfasts
OMPAC Board
8 AM, Plaza XIV, Stouffers
County Medical Society Executives
8 AM, Van Cleve III, Stouffers
Ophthalmology
8 AM, Dayton Room, Stouffers

Luncheons
Ophthalmology
12 Noon, Dayton Room, Stouffers
Sports Medicine
12 Noon, Wright Room, Sheraton
OMPAC
11:30 AM Cash Bar, Van Cleve III & IV
12 Noon Lunch, Van Cleve I & II, Stouffers
Ohio Committee on Trauma
12 Noon, Patterson Room, Sheraton
Neurosurgery
12:30 PM, King Cole Restaurant, Winters National Bank Building

OSMA Social Function
Dinner followed by production of *Cabaret*
Reception: 6:15 PM
Dinner: 7 PM
Cabaret: 8:30 PM, all at Wright State University (bus transportation furnished), $20 per person

Wednesday, May 10

Luncheons
Allergy and Immunology
12:30 PM, Montgomery Room, Sheraton
Committee on Scientific Work
12 Noon, Plaza XIV, Stouffers

$17 MILLION IN PREMIUMS WRITTEN OUR FIRST YEAR

This is one indication of PICO's quick rise to leadership in medical professional liability insurance.

Full details are provided in the first annual report to the growing number of PICO shareholders. Copies of this report also are being mailed this month to members of the OSMA who are not PICO shareholders. We think they'll be interested in the progress of our unique company.

PICO. Owned by physicians. Serving physicians.

Physicians Insurance Company of Ohio
P.O. Box 27905
6100 Channingway Boulevard
Columbus, Ohio 43227

Telephone (Toll-Free) 1-800-282-7515 for the name of the authorized PICO representative in your area.



Members of 1978 House of Delegates

By County: Delegates left column, Alternate Delegates right column.

First District

ADAMS COUNTY
William J. Lundy — Francis L. Stevens

BROWN COUNTY
John R. Donohoo — Gene F. Conway

BUTLER COUNTY
Robert E. Stegemiller — Joseph H. Brandabur

CLERMONT COUNTY
Carl A. Minning — William B. Selnick

CLINTON COUNTY
Foster J. Boyd

HAMILTON COUNTY

John E. Albers	Sanford Blank
Richard B. Budde	Harold Pescovitz
Edmund C. Casey	Mark Upson, Jr.
Charles D. Feuss, Jr.	Lee J. Vesper
Harry H. Fox	Walter B. Wildman
William H. Gates	John Wulsin
Robert J. Hasl	Allen J. Zobay
Robert S. Heidt	
Harry K. Hines	
Stephen P. Hogg	
Stanley J. Lucas	
Herbert G. Magenheim	
Richard L. Meyer	
William J. Schrimpf	
Carl G. Thompson, Jr.	

HIGHLAND COUNTY
Glenn B. Doan — Barbara Lustgarten

WARREN COUNTY
Thomas E. Fox — George Van Harlingen

Second District

CHAMPAIGN COUNTY
Isador Miller — John H. Flora

CLARK COUNTY
Ernest Winterhoff — William Harper
Henry A. Diederichs — Walter Lawrence

DARKE COUNTY
Jesse L. Heise — Jose R. Solis

GREENE COUNTY
Antonio Mannarino — Ray W. Barry

MIAMI COUNTY
A. Robert Davies — Jerry Hammon

MONTGOMERY COUNTY

R. Alan Baker	Robert K. Finley, Jr.
W. J. Lewis	D. Kiefer Campbell
John H. Boyles, Jr.	Richard G. Jenkins
John R. Whitaker, Jr.	Gilbert W. Hopkins
Frederic C. Schnebly	Walter A. Reiling, Jr.

PREBLE COUNTY
John D. Darrow

SHELBY COUNTY
George Schroer

Third District

ALLEN COUNTY

David A. Barr	Gene E. Wright
Joseph M. Oppenheim	Lawrence L. Young

AUGLAIZE COUNTY
David W. Nielsen — Elizabeth Y. Kuffner

CRAWFORD COUNTY
Johnson H. Chow — Virgil A. Auchard

HANCOCK COUNTY
William Kose — Edwin Davis

HARDIN COUNTY
Leonard K. Smith — Robert B. Elliott

LOGAN COUNTY
James Steiner

MARION COUNTY
Paul E. Lyon — Lee Johnson

MERCER COUNTY
James Otis — Donald R. Fox

SENECA COUNTY
James A. Murray — John Vela

VAN WERT COUNTY
Jack H. Cox — Harold C. Smith

WYANDOT COUNTY
Konstantine K. Solacoff — Joseph J. Browne

Fourth District

DEFIANCE COUNTY
Benedict B. Lenhart — Robert J. Foldvary

FULTON COUNTY
Benjamin H. Reed, Jr. — Vernon L. Cotterman

HENRY COUNTY
Robert J. Blough — Reynaldo C. Soriano

LUCAS COUNTY

John A. Devany	Donnan B. Harding, Jr.
Roland A. Gandy, Jr.	Robert L. Hauman
Frank E. Foss	Frederic C. Henry
Thomas J. O'Grady	James A. Jagodzinski
B. Leslie Huffman	Jerome Kimmelman
Peter A. Overstreet	Howard S. Madigan
Harry L. Snyder	S. Theodore Pinsky
Richard Wiseley	John R. Sadd

OTTAWA COUNTY
John F. Bodie — V. William Wagner

PAULDING COUNTY
Don K. Snyder — K. A. Pritchard

PUTNAM COUNTY
James B. Overmier — John R. Brown

SANDUSKY COUNTY
Samuel Lowery — Willis Damschroder

WILLIAMS COUNTY
John E. Moats — Robert Dilworth

WOOD COUNTY
Douglas Hess — Albert Smith

Fifth District

ASHTABULA COUNTY
M. Meshginpoosh — Samuel L. Altier

CUYAHOGA COUNTY
Felino V. Barnes — Matthew Biscotti
Donavin A. Baumgartner, Jr. — Nicholas G. DePiero
John H. Budd — Gilbert Derian
Roland D. Carlson — Clarence L. Huggins
Harvey J. Dworkin — Robert C. Kirk
Edwin H. Eigner — John A. Kmieck
Richard B. Fratianne — Daniel C. Maras
Ray W. Gifford — LeRoy W. Matthews
Robert A. Hahn — Valentin F. Mersol
Charles L. Hudson — George W. Petznick
Edward G. Kilroy — Walter H. Pritchard
Vincent T. LaMaida — William R. Pudvan
George P. Leicht — Elmer E. Raus
Leonard L. Lovshin — Antonio Antunez-Rodriguez
Richard J. Nowak — Filmore Schiller
Thomas P. Paras — A. Benedict Schneider
John G. Poulos — Joseph Schultz
P. John Robechek — Gilbert N. Silbiger
Franklyn Simecek — Peggy-Jeanne St. Clair
Frederick T. Suppes — H. S. Van Ordstrand
Warner Tuckerman — Allen E. Walker
Robert J. White — Albert M. Zippert

GEAUGA COUNTY
Bruce Andreas — Oscar Brinckmann

LAKE COUNTY
John Bukovnik — David Farrington
Harry Killian — Ronald J. Taddeo

Sixth District

COLUMBIANA COUNTY
William Banfield — Leonard S. Pritchard

MAHONING COUNTY
John C. Melnick — Karl F. Wieneke
J. James Anderson — Ernest Perry
C. Edward Pichette — Anthony T. Deramo
William E. Sovik — Rashid Abdu

STARK COUNTY
Edward E. Grable — Walter J. Telesz
Raymond J. McMahon, Jr. — Mark G. Herbst
E. Joel Davis — Robert C. Reed
Joseph P. Yut — Henry H. Clapper

TRUMBULL COUNTY
Robert J. Paul — Eduardo Angnardo
Joseph J. Sudimack, Jr. — John O. Vlad

Seventh District

BELMONT COUNTY
Lois R. Zimmerman — Norman Franklin

CARROLL COUNTY
Carl A. Lincke — Thomas J. Atchison

COSHOCTON COUNTY
Norman L. Wright — Robert R. Johnson

HARRISON COUNTY
Elias Freeman — Janis Trupovnieks

JEFFERSON COUNTY
Ronald Agresta — Augusto Fojas

MONROE COUNTY
Donald R. Piatt — Jack M. Matheny

TUSCARAWAS COUNTY
Philip T. Doughten — Benjamin J. Wherley

Eighth District

ATHENS COUNTY
John F. Kroner — Atmaram S. Gawande

FAIRFIELD COUNTY
James A. Merk — David H. Sheidler

GUERNSEY COUNTY
Robert A. Ringer — William S. Quigley

LICKING COUNTY
John P. Anderson, Jr. — Carl M. Frye

MORGAN COUNTY
Austin A. Coulson — Henry Bachman

MUSKINGUM COUNTY
John Ray — Gordon Gifford

NOBLE COUNTY
Edward G. Ditch — Frederick M. Cox

PERRY COUNTY
George Tedrow — Sydney N. Lord

WASHINGTON COUNTY
George B. Krivchenia — Kenneth E. Bennett

Ninth District

GALLIA COUNTY
Thomas P. Price, Jr. — Edward J. Berkich

HOCKING COUNTY
Lethia W. Starr — Jan Matthews

JACKSON COUNTY
John Zimmerly — Carl J. Greever

LAWRENCE COUNTY
A. Burton Payne — Harry Nenni

MEIGS COUNTY
Roger P. Daniels — Raymond E. Boice

PIKE COUNTY
Kenneth A. Wilkinson — Horace Giffen

SCIOTO COUNTY
George F. White — Chester H. Allen

VINTON COUNTY (not active)

Tenth District

DELAWARE COUNTY
David R. Smith, Jr. — Adelbert R. Callander

FAYETTE COUNTY
Robert A. Heiny — Marvin Roszmann

FRANKLIN COUNTY

Homer A. Anderson	Ben Arnoff
Michael A. Anthony	James E. Barnes
Robert C. Atkinson	Janet K. Bixel
Joseph A. Bonta	H. Gene Ewy
Richard L. Fulton	Frederick M. Kapetansky
Walter M. Haynes, Jr.	James F. Mason
George W. Paulson	James E. Matson
H. William Porterfield	Alexander Pollack
Jack E. Tetirick	J. Hutchison Williams

KNOX COUNTY
Henry T. Lapp — Roger H. Sherman

MADISON COUNTY
Sol Maggied — J. Richard Hurt

MORROW COUNTY
David J. Hickson — William S. Deffinger

PICKAWAY COUNTY
Ray Carroll — Henry H. Swope

ROSS COUNTY
Joseph S. McKell — Lewis Coppel

UNION COUNTY
Lawrence A. Gould — Walter R. Burt

Eleventh District

ASHLAND COUNTY
Jon Cooperrider — Charles H. Warne

ERIE COUNTY
Howard Smith — Robert Sawicki

HOLMES COUNTY
Luther W. High — Maurice Mullet

HURON COUNTY
Nino M. Camardese

LORAIN COUNTY

John Bartone	Henry Kleinhenz
Thomas Sfiligoj	Raymundo de la Pena
William F. Nichols	Andrew Mattey

MEDINA COUNTY
Richard W. Avery — Rolland Mansell

RICHLAND COUNTY

Harold F. Mills	James F. Clements
James W. Wiggin	Robert E. Barkett

WAYNE COUNTY
A. Burney Huff — John M. Robinson

Twelfth District

PORTAGE COUNTY
F. Michael Sheehan — Robert Arnold

SUMMIT COUNTY

Rocco M. Antenucci	Charles V. Bowen, Jr.
Roy E. Bugay	Arthur Dobkin
Robert R. Clark	Charles East
Douglas M. Evans	Manley Ford
Joseph L. Kloss	Paul D. Gatewood
W. Paul Kilway, Jr.	E. Gates Morgan
Marshall R. Werner	Fred F. Somma

OSMA OFFICERS

President ..... William M. Wells
President-Elect ..... John J. Gaughan
Past President ..... George N. Bates
Secretary-Treasurer ..... Robert G. Thomas

OSMA COUNCILORS

First District ..... Stewart B. Dunsker
Second District ..... W. J. Lewis
Third District ..... Alford C. Diller
Fourth District ..... C. Douglass Ford
Fifth District ..... Theodore J. Castele
Sixth District ..... C. Edward Pichette
Seventh District ..... Robert E. Rinderknecht
Eighth District ..... Richard E. Hartle
Ninth District ..... Thomas W. Morgan
Tenth District ..... J. Hutchison Williams
Eleventh District ..... S. Baird Pfahl, Jr.
Twelfth District ..... William Dorner, Jr.

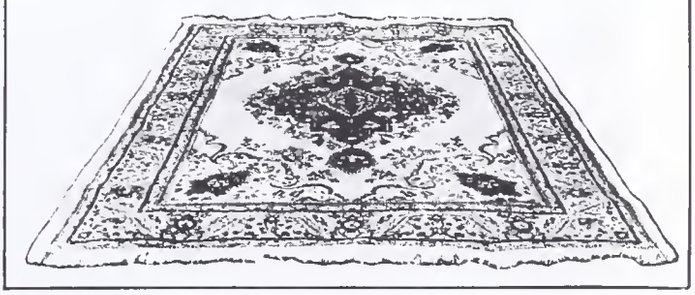
In Columbus
for over 65 years, since 1909,
K. A. Menendian
has been known for
the finest quality and best values in
ORIENTAL RUGS.

We carry a complete selection of rugs from mats to mansion sizes. Over 1500 rugs in stock from Iran, India, China, Pakistan, Turkey, etc.

See over 4,000 samples in our newly remodeled carpet showroom from Karastan and other fine mills.

We specialize in Oriental rug cleaning and repairing.

K.A.Menendian
1090 West Fifth Avenue
294-3345




Kefzol® I.M./I.V.
cefazolin sodium
Ampoules, equivalent to 500 mg., 1 Gm.,
and 10 Gm. of cefazolin
NDC 0002-7014-01
AMPOULE No. 7014
KEFZOL®
STERILE
CEFAZOLIN
SODIUM
Equivalent to
10 Gm.
Cefazolin
Protect from Light
PHARMACY
BULK PACKAGE
KEFZOL
STERILE CEFAZOLIN
SODIUM
500 mg.
KEFZOL
SODIUM
1 Gm.
Additional information available
to the profession on request.
Eli Lilly and Company
Indianapolis, Indiana 46206
700773



Physicians' Art Show

Space will be provided at the 1978 OSMA Annual Meeting, May 6-10, 1978, for a Physicians' Art Show. An art award committee will judge the exhibit displayed at the Dayton Convention Center, and will present awards. The winning entries from the Ohio State Medical Journal Photographic Exhibit will be displayed alongside the art exhibit.

The OSMA will provide suitable display facilities and the Art Show Committee will take responsibility for the display arrangement. Final acceptance for display will be at the discretion of the Art Show Committee.

OSMA members and spouses are invited to apply for entry of not more than two pieces of art per person. Each physician is responsible for the transportation of his/her works of art to the Dayton Convention Center. All expenses involved in transportation, packing, and unpacking are the responsibility of the physician or his spouse.

When applying, please include a brief description (or picture if possible) of the work of art (title, dimensions) and list them in order of preference for acceptance in case all cannot be accommodated.

Art Show Application Form

For further information and return of application form:

Ludolph H. van der Hoeven, M.D., Chairman, Art Show Committee
2222 Philadelphia Drive
Dayton, Ohio 45406
Telephone: 513/278-2612, Ext. 140

NAME_____ SPOUSE'S NAME_____

ADDRESS_____

CITY_____ TELEPHONE_____

ARTWORK (Include dimensions — depth, width, height.)

_____

OSMA Social Function In Honor of AMA President and Mrs. John H. Budd

May 9, 1978

Ohio has many outstanding physicians, but none of whom Ohioans could be more proud than John H. Budd, M.D., Cleveland, President of the American Medical Association. His election to the AMA presidency culminated a life dedicated to not only his patients but also his fellow physicians. John Budd has truly given his life to the betterment of health care.

It is with pride that the Ohio State Medical Association honors Dr. Budd and his wife, Irma, at the 1978 Annual Meeting Social Function. If a pun might be allowed, it will be a "budding affair" of laughter, music, interchange, and merriment.





Irma and John Budd

The Social Function will be held May 9, 1978 at Wright State University. Beginning with cocktails at 6:15 PM in the Faculty Dining Room and dinner at 7 PM, the evening will be highlighted by a university performance of *Cabaret* in the Festival Playhouse. Bus transportation will be provided between convention hotels and the university. Cost of the evening is $20 per person.

Cabaret is set in Berlin in the late 1920s, where the coming Nazi doom places the city in a mood of frenetic activity. Within this framework, the characters lead their lives of hope, anxiety, and decadence. The musical comes from John Van Druten's play *I Am a Camera,* which is a dramatization of stories by Christopher Isherwood, who wrote about the people of Berlin in the pre-war years.

The stage play of *Cabaret* is much different than the movie of the same name. Many of the songs are the same, as are some of the characters. However, the play is much less a vehicle for a star. It is an examination of several characters and how their lives touched and reacted within a period of time that effected the entire world.

The OSMA invites you and your spouse to enjoy an evening of dining and theater and to join in our tribute to AMA President and Mrs. John H. Budd.

Come, come to the Cabaret!

)MPAC Presents
Vashington Columnist, Robert D. Novak

t Luncheon in Conjunction With
978 OSMA Annual Meeting
uesday, May 9, 1978



Robert D. Novak

The Ohio Medical Political Action Committee)MPAC) speaker at the 1978 OSMA Annual Meeting ll be Washington columnist, Robert D. Novak. Mr. ovak will address the OMPAC luncheon, Tuesday, May held in conjunction with the OSMA Annual Meeting. he luncheon will begin with a social period at 11:30 M, followed by lunch at noon. The location is the ouffers Dayton Plaza.

A part of the writing team of Evans and Novak, hose column "Inside Report" is syndicated in more an 250 newspapers here and abroad, Robert Novak is ten described as a news-hungry journalist who spe-alizes in investigation and probing analysis instead of mchair commentary. Robert Novak's name became well spected on Washington's Capitol Hill from his days as hief Congressional Correspondent for *The Wall Street urnal;* since 1963, when he and Rowland Evans, Jr., ined forces to start their column, their success has been itstanding.

Novak and Evans give appraisals from behind the enes of significant and unexpected developments on itional, state, and local trends as well as cover the international scene. Their reports have been known to come from four different states in one week, and Mr. Novak has crisscrossed the country numerous times to test grass-roots sentiment. He travels abroad frequently, making at least one trip each year.

Robert Novak is a graduate of the University of Illinois and began his newspaper career in his home-town on the Joliet *Hearld News.* After serving with the rank of lieutenant in the Korean War, he joined the Associated Press Omaha office and later continued with the news service in Lincoln, Nebraska and Indianapolis. In 1957, he went to Washington as Capitol Hill correspondent for the Associated Press. He transferred to *The Wall Street Journal* in 1958 as Senate correspondent and political reporter, later becoming their chief congressional correspondent.

Since 1963, he and Rowland Evans, Jr., have been writing "Inside Report" and a biweekly newsletter, the "Evans-Novak Political Report." Mr. Novak has also written *The Agony of the G.O.P.* (1964) and, with Mr. Evans, wrote *Lyndon B. Johnson: The Exercise of Power* (1966) and *Nixon in the White House* (1971).

Ohio State Medical Association
1978 Annual Meeting

May 5-10, 1978 ***Dayton, Ohio***

REGISTRATION FORM

Please register me for the following Annual Meeting activities:

Date/Activity	Fee
Friday, May 5	
☐ Basic Life Support (CPR)	$50
Saturday, May 6, and Sunday, May 7	
☐ Advanced Life Support (CPR)	$140
☐ Development and Evaluation of AV Instructional Material	$100
☐ Medical Writing	$60
☐ Negotiations	$140
Monday, May 8	
☐ Dermatology	$60
BUS TOURS	
☐ Dayton Medical Facility "Show and Tell"	No Fee
☐ Wright State University School of Medicine	No Fee
☐ United States Air Force Museum	No Fee
Tuesday, May 9	
☐ OMPAC Luncheon	$10/person
☐ OSMA Social Function: Dinner and Theater	$20/person
Tuesday, May 9, and Wednesday, May 10	
☐ Postgraduate Courses	$40

#1: Electrolytes and Blood Gases
#2: Therapeutic Logic in Common Drug Interactions
#3: How to Deal With Alcoholic Patients in Practice
#4: Pediatric Emergencies
#5: Death and Dying

1st Choice: Course #____ 2nd Choice: Course #____ 3rd Choice: Course #____

Total Fee: _____

Make checks payable to: Ohio State Medical Association

NAME_____

ADDRESS_____
(Street) (City) (State) (ZIP

I am ☐ OSMA Member ☐ Medical Student ☐ Please prepare guest badge for my spouse.
☐ Non-member Physician ☐ Guest
☐ Other_____

Mail form to: **Department of Continuing Medical Education, Ohio State Medical Associaton**
600 South High Street, Columbus, Ohio 43215

Time is the test of all things.

1954
1978



BRIEF SUMMARY

Indications: Oral potassium therapy for the prevention and treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. May be used in the treatment of cardiac arrhythmias due to digitalis intoxication.

Contraindications: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause.

Precautions: Potassium intoxication by oral administration rarely occurs in patients with normal kidney function, however, potassium supplements must be administered with caution, since the amount of the deficiency or daily dosage is not accurately known. Frequent checks of the clinical status of the patient, and periodic ECG and/or serum potassium levels should be made. High serum concentrations of potassium ion may cause death through cardiac depression, arrhythmias or arrest. This drug should be used with caution in the presence of cardiac disease.

In hypokalemic states, especially in patients on a low-salt diet, hypochloremic alkalosis is a possibility that may require chloride as well as potassium supplementation.

Adverse Reactions: Nausea, vomiting, diarrhea, and abdominal discomfort have been reported. The most severe adverse effect is hyperkalemia.

Overdosage: Potassium intoxication may result from overdosage of potassium or from therapeutic dosage in conditions stated under "Contraindications". Hyperkalemia, when detected, must be treated immediately because lethal levels can be reached in a few hours.

Kaon® Elixir
(potassium gluconate)
20 mEq per 15 ml

WARREN-TEED
LABORATORIES, INC.
DIVISION OF **ADRIA LABORATORIES INC.**
COLUMBUS, OHIO 43215

Resolutions for the 1978 House of Delegates

EDITOR'S NOTE: The following resolutions affecting the Ohio State Medical Association Constitution and Bylaws have been submitted for consideration by the OSMA House of Delegates at the 1978 Annual Meeting. A pamphlet containing all resolutions may be obtained by contacting OSMA Headquarters Office, 600 South High Street, Columbus, Ohio 43215, telephone 614/228-6971.—*L.A.P.*

#2 **Grass Roots Representation to AMA**
(By Summit County Medical Society)

BE IT RESOLVED, That component county medical societies, groups or districts of counties, be privileged to seat one physician member elected by the county medical society(s) as part of their state delegation to the AMA for each 500 members of their county medical society(s), holding *local and state membership;* and BE IT FURTHER

RESOLVED, That these delegates be in addition to the present delegates seated in the AMA House by the state association and be members of AMA; and BE IT FURTHER

RESOLVED, That two (2) years from the adoption of this program of expanded member involvement in AMA, the *enabling number* of members for a county society(s) delegation be required to be *members* of AMA; and BE IT FURTHER

RESOLVED, That the AMA delegates from OSMA introduce and support the necessary bylaw changes in the AMA to enable this program of grass roots representation; and BE IT FURTHER

RESOLVED, That the Council of OSMA construct the necessary changes in the OSMA Constitution and Bylaws for action by the House of Delegates at its next regular meeting.

#4 **Automatic Termination of Membership**
(By Summit County Medical Society)

WHEREAS, OSMA Bylaws, Chapter I, Section 5, Effect of Expiration, Revocation, or Termination of Certificate presently reads, "Membership in this Association of a member in active practice whose certificate to practice medicine and surgery has expired, has been revoked, or has been otherwise terminated, shall be cancelled automatically as of the effective date of such expiration, revocation or termination. The provisions of this Section 5 shall not apply to members who have retired from active practice,"; and

WHEREAS, This provision does not permit the usual right of a member for a hearing prior to termination of membership; and

WHEREAS, Voluntary suspension of certificate by a physician is sometimes necessary in the Physicians Effectiveness Program, and continued membership in the state and county medical societies may be vitally important in the rehabilitation of the physician; and

WHEREAS, The Councils of the state and county medical societies have the basic responsibility of determining continued membership in the organizations and this responsibility should not be automatically transferred to another organization, namely the State Medical Board; THEREFORE BE IT

RESOLVED, That Chapter I, Section 5, Effect of Expiration, Revocation, or Termination of Certificate, be changed to read as follows: "The expiration, revocation or otherwise termination of the certificate to practice medicine and surgery of a member in active practice shall automatically require Council action. If cancellation of membership is the contemplated action, a hearing as provided in Section 7 is to occur at the local society level and/or at the state level prior to effecting the cancellation of membership. The provisions of this Section 5 shall not apply to members who have retired from active practice."

#5 **Composition of Resolutions Committees**
(By Huron County Medical Society)

WHEREAS, The functions of Representative Government are best served and fostered by "local" representation to Reference Committees; THEREFORE BE IT

RESOLVED, That the House of Delegates of the Ohio State Medical Association seriously consider and adopt the following policy:

1. That the Delegates of each District shall elect a number of their members to serve on the Resolutions Committees. The number of members elected shall be equal to the number of Resolutions Committees.

2. That the President of the Ohio State Medical Association shall appoint committee members to each Resolutions Committee from the elected Delegates.

3. That each Resolutions Committee shall elect its own Chairman.

4. That each District shall be represented on each Resolutions Committee.

#7 **Amendment to OSMA Bylaws**
Resolutions Committees
(By Huron County Medical Society)

WHEREAS, Chapter 4, Section 4, of the Ohio State Medical Association Bylaws "Committees of the House of Delegates" gives the President of the Ohio State Medical Association unlimited powers in appointing Resolutions Committees; and

WHEREAS, The functions of representative government are best served and fostered by "local" representation to Reference Committees; THEREFORE BE IT

RESOLVED, That Chapter 4, Section 4, of the Bylaws of the Ohio State Medical Association shall be amended to have a Subsection 4A titled "Committees on Resolutions"— to read as follows: "The President of the Ohio State Medical Association shall appoint Committees on Resolutions. The members of each committee shall qualify as follows:

1. The Delegates of each District shall elect a number of their members to serve on the Resolutions Committees. The number of members elected shall be equal to the number of Resolutions Committees.

2. The President of the Ohio State Medical Association shall appoint committee members to each Resolutions Committee from the elected Delegates.

3. Each Resolutions Committee shall elect its own Chairman.

4. Each District shall be represented on each Resolutions Committee.

#10 **OSMA Interim Meeting**
(By Stark County Medical Society)

WHEREAS, The pace of medical progress has been greatly accelerated in the past ten years; and

WHEREAS, The American Medical Association has recognized this fact and now holds an interim session of its House of Delegates on an annual basis; and

WHEREAS, Twenty-two states now hold annual or interim sessions of their Houses of Delegates within ninety days of the interim session of the House of Delegates of the American Medical Association, thus giving them the opportunity of introducing current and/or timely resolutions; THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association's House of Delegates meet in interim session not more than sixty nor less than thirty days prior to the interim session of the House of Delegates of the American Medical Association, such meeting to be for not less than one nor more than three days duration; and BE IT FURTHER

RESOLVED, That, in the interest of economy, this meeting be held in Columbus, Ohio using to the greatest extent possible facilities of the headquarters of the Ohio State Medical Association.

Fiscal Note: Two-day meeting $3,000
Three-day meeting $5,000

#12
Speaker and Vice Speaker for the House of Delegates
(By Lima and Allen County Academy of Medicine, David A. Barr, M.D., Delegate)

WHEREAS, The House of Delegates is the governing and policy-making body of the Ohio State Medical Association; and

WHEREAS, The President of the Ohio State Medical Association is the spokesman for and the advocate of the policies of organized medicine in Ohio; and

(Resolutions continued on page 224)

★
Specialized Service
IN
PROFESSIONAL LIABILITY INSURANCE
is a high mark of distinction

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

OHIO OFFICES:
CINCINNATI: Raam 700, 3333 Vine Street, (513) 751-0657, L. A. Flaherty
CLEVELAND: Suite 106, 23360 Chagrin Baulevard, Beachwaad 44122, (216) 464-9950
A. C. Spath, Jr., R. A. Zimmerman
COLUMBUS: 1989 West 5th Ave., (614) 486-3939, J. E. Hansel
TOLEDO: 1011 Sandusky St., Suite H, P.O. 8ax 331, Perrysburg 43551, (419) 874-8080, R. E. Stallter


"In a real dark night of the soul
it is always three o'clock in the morning."
—F. SCOTT FITZGERALD
THE CRACKUP, 1936

Insomnia
a shade of blue that often accompanies depression

And, in anxiety/depression, Adapin® (doxepin HCl) often helps restore disturbed sleep patterns, such as early morning awakening, with a single daily dose at bedtime! Adapin quickly relieves the patient's anxiety, gradually brightens his mood and outlook, with optimal antidepressant response usually evident within two to three weeks.

1. Goldberg HL, Finnerty RJ, Cole JO: Doxepin: Is a single daily dose enough? *Am J Psychiatry* 131:1027-1029, 1974.

Brief Summary of Prescribing Information
ADAPIN® (doxepin HCl) Capsules

Indications—Relief of symptoms of anxiety and depression.

Contraindications—Glaucoma, tendency toward urinary retention, or hypersensitivity to doxepin.

Warnings—Adapin has not been evaluated for safety in pregnancy. No evidence of harm to the animal fetus has been shown in reproductive studies. There are no data concerning secretion in human milk, nor on effect in nursing infants.

Usage in children under 12 years of age is not recommended. MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with this drug, as serious side-effects and death have been reported with the concomitant use of certain drugs and MAO inhibitors.

In patients who may use alcohol excessively potentiation may increase the danger inherent in any suicide attempt or overdosage.

Precautions—Drowsiness may occur and patients should be cautioned against driving a motor vehicle or operating hazardous machinery. Since suicide is an inherent risk in depressed patients they should be closely supervised while receiving treatment. Although Adapin has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Adverse Reactions—Dry mouth, blurred vision and constipation have been reported. Drowsiness has also been observed.

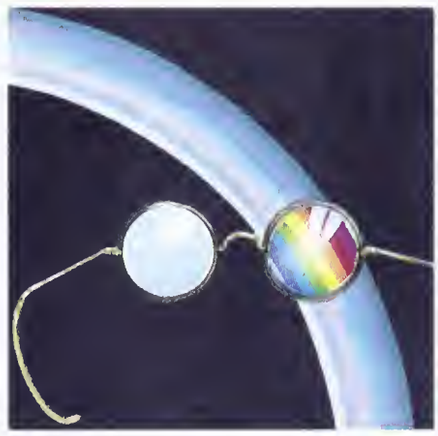
Adverse effects occurring infrequently include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as sweating, tachycardia and hypotension. Weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash and pruritus may also occur.

Dosage and Administration—In mild to moderate anxiety and/or depression: 25 mg t.i.d. Increase or decrease the dosage according to individual response. Daily dosage, up to 150 mg may be taken at bedtime without loss of effectiveness. Usual optimum daily dosage is 75 mg to 150 mg per day not to exceed 300 mg per day.

Antianxiety effect usually precedes the antidepressant effect by two or three weeks.

How Supplied—Each capsule contains doxepin, as the hydrochloride: 10 mg, 25 mg, 50 mg and 100 mg capsules in bottles of 100 and 1000.

For complete prescribing information please see package insert or PDR.



When they see life in shades of blue... help them see life in all its colors.

Adapin®
(doxepin HCl)

single daily dose recommended h.s.



10 mg capsules
25 mg capsules
50 mg capsules
NEW 100 mg capsules

PENNWALT
Pennwalt Prescription Products
Pharmaceutical Division
Pennwalt Corporation
Rochester, New York 14603

Resolutions *(continued)*

WHEREAS, The organization and management of the House of Delegates has become more and more complex, technical and time consuming; and

WHEREAS, The responsibilities and duties of the President during the year and at the House of Delegates meetings have increased and become more important as a spokesman for Ohio Medicine; and

WHEREAS, The functioning of the House of Delegates would be more efficient and orderly under the direction of a Speaker and Vice Speaker; and

WHEREAS, The President would be more effective as a spokesman for medicine if he did not have the responsibility of leading the House of Delegates; THEREFORE BE IT

RESOLVED, That the Constitution and Bylaws Committee of the Ohio State Medical Association be instructed to prepare appropriate Constitutional Amendments to create the positions of Speaker and Vice Speaker of the House of Delegates of the Ohio State Medical Association. These positions to be elected each year; and BE IT FURTHER

RESOLVED, That the Constitution and Bylaws Committee prepare appropriate Constitutional Amendments to add the Speaker and Vice Speaker of the House of Delegates to the Council of the Ohio State Medical Association with full voting rights; and BE IT FURTHER

RESOLVED, That the Constitutional Amendments be presented to the House of Delegates for ratification at the 1979 Annual Meeting of the House.

#14 Special Meetings of OSMA House of Delegates

(By Robert R. Clark, M.D., Summit County, and P. John Robechek, M.D., Cuyahoga County)

WHEREAS, the 1977 revision of the Constitution and Bylaws of the Ohio State Medical Association states: Special meetings of the House of Delegates shall be called by the President or other officer upon a two-thirds vote of the Council or upon the filing with Executive Director of this Association of a petition duly authorized by the presidents of at least twenty-three (23) component societies; and

WHEREAS, The figure 23 is one *more* than one-quarter of the 88 component societies in the Ohio State Medical Association; and

WHEREAS, Under this rule a very small group of members of the Ohio State Medical Association may demand that a special meeting be held; and

WHEREAS, The obvious intent of the establishment of 23 component societies is to indicate that more than one-quarter of the component societies be required to petition for a special meeting, with no consideration of the number of Ohio State Medical Association *members* be required to so petition; and

WHEREAS, Truly democratic, grass roots involvement requires that members, not only component societies be represented and should be to the extent of one-quarter plus one of the members (which would have been 2,775 of the 11,099 members as of December 31, 1977, as appropriate for 1978); THEREFORE BE IT

RESOLVED, That Article V of the Constitution and Bylaws be amended to read as follows: Special meetings of the House of Delegates shall be called by the President or other officer upon a two-thirds vote of the Council or upon the filing with the Executive Director of this Association a petition duly authorized and signed by the presidents of at least twenty-three (23) component societies, *representing at least one more than one quarter of the members of the Ohio State Medical Association.*

#15 Interim Sessions of OSMA House of Delegates

(By Academy of Medicine of Cleveland)

WHEREAS, The issues facing organized medicine are growing, both in number and complexity; and

WHEREAS, It is increasingly difficult for the Council of OSMA to secure the input from the members of the House of Delegates which therefore contributes to the feeling by some physicians that the OSMA is not responsive to the needs and feelings of the members; THEREFORE BE IT

RESOLVED, That the Constitution and Bylaws of the Ohio State Medical Association be amended to provide for Interim Sessions of the House of Delegates of the Ohio State Medical Association and that these sessions be held four to six weeks prior to the Annual and/or Interim Sessions of the AMA House of Delegates.

Fiscal Note: $5,000-$7,000 per day

#18 OSMA Election Rules

(By James B. Evans, M.D., Member, Montgomery County Medical Society)

WHEREAS, Any democratic body exercises its power and expresses its will through the direct election of its officers by a ballot of its members;

WHEREAS, The leaders of the Ohio State Medical Association are not elected at present by its members, but are elected by the House of Delegates, in order to assure that the policies of the Ohio State Medical Association accurately reflect the interests and aims of its members; BE IT

RESOLVED, That the Ohio State Medical Association's election rules be changed so that its President and other top officers will be elected by a direct ballot of the individual members.

The next best thing to a 25-hour day.

Designed exclusively for the kind of physician who could use at least 25 hours in every day, 8 days a week, 53 weeks a year. The kind of physician who recognizes the value of efficiency in everything from speed reading to a skilled head nurse. Because that's the kind of physician who knows that a more efficient practice is the key to more efficient patient care.

And that's what we're all about.

The Physician's Computer Data System is pre-programmed exclusively to handle the physician's needs. Needs such as: insurance forms, patient records, billing, and other ledger information. And all of it in a fraction of the time it takes a person to do it.

But just about any person can be taught to operate it. Anyone that you choose from your staff will be trained at the same time we install the System and feed it your files and records.

They won't have to learn any special "computer talk" either. Because the Physician's Computer Data System is programmed in the same plain language as we're using here. Even the three component parts which make up the System are called quite plainly: the Computer, the Printer, and the Terminal.

And the Physician's Computer Data System will slip as easily into your budget as it does your everyday office procedure and staff makeup. With a leasing program of just $385 a month. (That includes installation and training.)

So maybe we can't give you that 25th hour a day. But with the Physician's Computer Data System, you get just a little more out of 24.

The computer data system developed exclusively for the physician.

Send for complete details.

Microtech, Inc.
1127 S. Sixth St.
Louisville, Kentucky 40203

Name_____

Address_____

City_____ State_____ Zip_____

THE PHYSICIAN'S COMPUTER DATA SYSTEM, by MICROTECH.

INFECTION!
–a "dirty" word to surgeons...



...'ANCEF' helps "clean up" the site

'ANCEF' Offers Broad Coverage

of major areas of postsurgical infection due to susceptible indicated organisms (See Brief Summary below).

High, Prolonged Serum Levels Mean

most infections can be treated with 500 mg to 1 gram every 8 hours.

Cefazolin Levels in Tissues and Fluids*

'Ancef' is present in bone, synovial fluid, skin and soft tissues (such as pleural fluid and lymph nodes).

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

Indications: Ancef® (sterile cefazolin sodium, SK&F) is indicated in the treatment of the following serious infections due to susceptible organisms.

Respiratory tract infections due to *Streptococcus (Diplococcus) pneumoniae, Klebsiella* species, *Hemophilus influenzae, Staphylococcus aureus* (penicillin-sensitive and penicillin-resistant), and group A beta-hemolytic streptococci.

Injectable benzathine penicillin is considered to be the drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever.

'Ancef' is effective in the eradication of streptococci from the nasopharynx; however, data establishing the efficacy of 'Ancef' in the subsequent prevention of rheumatic fever are not available at present.

Genitourinary tract infections due to *Escherichia coli, Proteus mirabilis, Klebsiella* species, and some strains of enterobacter and enterococci.

Skin and soft-tissue infections due to *S. aureus* (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci and other strains of streptococci.

Bone and joint infections due to *S. aureus.*

Septicemia due to *Str. pneumoniae, S. aureus* (penicillin-sensitive and penicillin-resistant), *P. mirabilis, E. coli,* and *Klebsiella* species.

Endocarditis due to *S. aureus* (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci.

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to 'Ancef'.

Contraindications: 'Ancef' is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: BEFORE CEFAZOLIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS.

SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Antibiotics, including 'Ancef', should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Usage in Pregnancy—Safety of this product for use during pregnancy has not been established.

Usage in Infants—Safety for use in prematures and infants under one month of age has not been established.

Precautions: Prolonged use of 'Ancef' may result in the overgrowth of nonsusceptible organisms. Careful clinical observation of the patient is essential.

When 'Ancef' is administered to adults or children with low urinary output because of impaired renal function, lower daily dosage is required (see dosage instructions in the package literature).

A false-positive reaction for glucose in the urine may occur with Clinitest® tablets; use glucose enzyme-type reagents.

Adverse Reactions: The following reactions have been reported: Drug fever, skin rash, vulvar pruritus, eosinophilia, neutropenia, leukopenia, thrombocythemia, and positive direct and indirect Coombs tests have occurred. Transient rise in SGOT, SGPT, BUN, and alkaline phosphatase levels has been observed without clinical evidence of renal or hepatic impairment. Nausea, anorexia, vomiting, diarrhea, and oral candidiasis (oral thrush) have been reported. Pain at the site of injection after intramuscular administration has occurred, some with induration. Phlebitis at the site of injection has been noted. Other reactions have included genital and anal pruritus, genital moniliasis, and vaginitis.

Administration and Dosage: 'Ancef' may be administered intramuscularly or intravenously after reconstitution. See the package literature for reconstitution procedures.

See the package literature for dosage recommendations.

How Supplied: 'Ancef' (sterile cefazolin sodium, SK&F)—supplied in vials equivalent to 250 mg., 500 mg. or 1 gram of cefazolin; in "Piggyback" Vials for intravenous admixture equivalent to 500 mg. or 1 gram of cefazolin; and in Pharmacy Bulk Vials equivalent to 5 grams or 10 grams of cefazolin.

ANCEF® IV IM

brand of sterile

CEFAZOLIN SODIUM

(LYOPHILIZED)

Injection: 250 mg, 500 mg, and 1 gram vials

Smith Kline & French Laboratories
Philadelphia, Pa.

SK&F
a SmithKline company

*Tissue penetration is regarded as essential to therapeutic efficacy; however, specific tissue levels have not been correlated with specific therapeutic results.

Air Force Aerospace Medicine is just what the doctor ordered.



Adding wings and a uniform to your profession won't change your career — much. You'll be a doctor with all the advantages of an Air Force officer. That includes an opportunity to learn the latest about Aerospace Medicine and a chance to fly and observe aircrew members — adding a new dimension to your medical career. You'll have a thriving practice, not dependent on the ability to pay. You'll find, too, that with our group practice setting you should have more time for your family and the many recreational facilities that most bases have. Included is a liberal annual vacation plan.

Examine your opportunities now

Mail the coupon below for all the information.

USAF MEDICAL RECRUITING

Post Office & Court House Bldg.
Rm. 301, Government Square
Cincinnati, Ohio 45202
Phone: 513/381-4141

16101 Snow Rd.
Suite 300
Cleveland, Ohio 44142
Phone: 216/522-4325

Name _____ Social Security No. _____

Address _____

City _____

State _____ Zip _____ Phone _____

Specialty _____

Date of Birth _____

AIR FORCE... A Great Way of Life

Continuing Medical Education Courses

NOTE: To register for courses with an asterisk (*) following the fee, use the 1978 OSMA Annual Meeting Registration Form found in this publication.

Postgraduate Courses

#1 ELECTROLYTES AND BLOOD GASES

CME Hours: 4 Category I
Fee: $40*
Date: Tuesday, May 9, and Wednesday, May 10
Place: Montgomery Room, Sheraton
Time: 7:30-9:30 AM each morning
Sponsor: OSMA Committee on Scientific Work

Course Director: *David P. Nicholson, M.D., F.R.C.P., F.A.C.P.,* Professor of Medicine, Director of the Pulmonary Disease Group, Wright State University School of Medicine, Dayton

Faculty: *Gary A. Fehrman, M.D.,* Assistant Clinical Professor of Medicine, Wright State University School of Medicine

H. Allan Feller, M.D., Associate Clinical Professor of Medicine, Director, Group in Nephrology, Wright State University School of Medicine

Richard A. Serbin, M.D., Clinical Professor of Medicine; Director, Group in Endocrinology, Wright State University School of Medicine

Robert A. Weisman, Ph.D., Chairman, Biological Chemistry, Wright State University School of Medicine

Course Description: Current concepts in electrolyte disturbances and acid-base balance as seen in an intensive care unit, where patients with respiratory failure, acute myocardial infarction, and endocrinopathies receive primary and immediate scrutiny. Actual examples, particularly those stemming from the combination of diuretic therapy and systems disease interactions will be used for problem-solving by course participants.

#2 THERAPEUTIC LOGIC IN COMMON DRUG INTERACTIONS

CME Hours: 4 Category I
Fee: $40*
Date: Tuesday, May 9, and Wednesday, May 10
Place: Dayton Room, Sheraton
Time: 7:30-9:30 AM each morning
Sponsor: OSMA Committee on Scientific Work

Course Director: *John Lindower, M.D., Ph.D.,* Chairman, Department of Pharmacology, Wright State University School of Medicine, Dayton

Course Description: Will address the problem that the physician can never prescribe drugs in an isolated condition or to an isolated organ system. Single drugs given to the human can have effects on all organ systems. Summary responses to several drugs given in concert must be estimated on the basis of known mechanisms of each interacting agent. Common clinical baseline conditions of alcoholic intake, general anesthesia, antihypertensives, psychotropics, and non-prescription drugs will be examined with concurrent drug treatment. Effort will be made to define clinical outcome when commonly used drugs are interacted with the above baseline categories of "pharmacological setting."

#3 HOW TO DEAL WITH ALCOHOLIC PATIENTS IN PRACTICE

CME Hours: 4 Category I
Fee: $40*
Date: Tuesday, May 9, and Wednesday, May 10
Place: Patterson Room, Sheraton
Time: 7:30-9:30 AM each morning
Sponsor: OSMA Committee on Scientific Work

Course Director: *Abraham Heller, M.D.,* Professor of Psychiatry and Community Medicine, Department of Psychiatry, Wright State University, Dayton

Course Description: Alcoholism affects millions and is universally present in medical practice, yet identification of the condition is infrequent despite existing tests and criteria promoting earlier and more certain diagnosis. Although medical responsibility is beyond question, many practitioners are reluctant and elect non-involvement. Doctors underestimate the potential for meaningful intervention which requires only the very same skills as for any chronic illness with resistant, non-compliant patients

#4 PEDIATRIC EMERGENCIES

CME Hours: 4 Category I
Fee: $40*
Date: Tuesday, May 9, and Wednesday, May 10
Place: Wright Room, Sheraton
Time: 7:30-9:30 AM each morning
Sponsor: OSMA Committee on Scientific Work

Course Director: *Charles H. Wharton, M.D.,* Director of Medical Education and Associate Professor of Pediatrics, Wright State University School of Medicine

Course Description: Sponsored by Wright State Univer-

(continued on next page)

Postgraduate Courses *(continued)*

sity School of Medicine, Department of Pediatrics, in conjunction with the Dayton Children's Medical Center. Topics for presentation will be Medical and Surgical Emergencies of the Newborn, Diagnostic and Therapeutic Aspects of Acute Airway Obstruction, and Diagnosis and Management of Anathylaxis

#5 DEATH AND DYING

CME Hours: 4 Category I
Fee: $40*
Date: Tuesday, May 9, and Wednesday, May 10
Place: Kettering Room, Sheraton
Time: 7:30-9:30 AM each morning
Sponsor: Committee on Scientific Work
Course Director: *Roger D. Blackwell, Ph.D.,* Professor of Administrative Science, Ohio State University, Columbus, teaching primarily in the areas of consumer behavior research and marketing strategy. Co-author, *Consumer Behavior* and *Consumer Attitudes Toward Health Care and Medical Malpractice,* a study conducted through a grant from the OSMA Task Force on Professional Liability
Course Description: Analyzes the changing attitudes toward death in America and the implications of these changes for a doctor-patient relationship. Uses a socioeconomic analysis of death in a contemporary society, as well as a psychological analysis of patient reactions to death and grief. Examines the effect of changing mortality in a community and draws heavily from material in Dr. Blackwell's recent book entitled *Living with Death.* Dr. Blackwell teaches the course "Death and Society" at Ohio State University. He also wrote his doctoral dissertation on death and funerals.

Special Interest Programs

ADVANCED LIFE SUPPORT (CPR)

CME Hours: 14 Category I
Fee: $140*
Date: Saturday, May 6, and Sunday, May 7
Place: Rooms 302-303, Dayton Exhibition Center
Time: 8 AM-6 PM Saturday
8 AM-6 PM Sunday
Sponsor: OSMA Committee on Scientific Work in cooperation with the Ohio Heart Association
Course Director: *William H. Gates,* Cincinnati
Faculty: Mark Popil, M.D., Cincinnati; Thomas Saladin, M.D., Cincinnati; Robert Davies, M.D., Dayton; Richard Levy, M.D., Cincinnati; Jan Craig, R.N., Cincinnati; Richard Turner, P.A., Cincinnati; Gary Miller, Cincinnati; Dudley Smith, Cincinnati; C. W. Abbott-Smith, M.D., Cincinnati; Robert Ritzi, M.D., Cincinnati; and Richard Schorr, M.D., Cincinnati
Course Description: Certification in Basic Life Support is a prerequisite for this course. In cooperation with the Ohio Heart Association, Advanced Life Support course provides instruction in the following: use of adjunctive equipment, arrhythmia recognition and cardiac monitoring, defibrillation and cardioversion, establishing and maintaining intravenous fluid lifelines, drug therapy to correct acidosis shock, and serious arrhythmias; and stabilization of the patient's condition for transportation. Registrants will be certified according to the standards of the American Heart Association.

BASIC LIFE SUPPORT (CPR)

CME Hours: 5 Category I
Fee: $50*
Date: Friday, May 5
Place: Room 302-303, Dayton Exhibition Center
Time: 1-6 PM
Sponsor: OSMA Committee on Scientific Work in cooperation with the Ohio Heart Association
Course Director: *William H. Gates, M.D.,* Cincinnati
Faculty: Robert Davies, M.D., Dayton; Richard Levy, M.D., Cincinnati; Jan Craig, R.N., Cincinnati; Gary Miller, Cincinnati; Dudley Smith, Cincinnati; and Richard Schorr, M.D., Cincinnati
Course Description: Course will cover early warning signs and signals for survival from sudden respiratory and cardiac arrest. The practical skills in the management of one- and two-person CPR; infant resuscitation; relief of an obstructed airway; and unwitnessed cardiac arrest will be covered.

DEVELOPMENT AND EVALUATION OF AUDIO-VISUAL INSTRUCTIONAL MATERIALS

CME Hours: 10 Category I
Date: Saturday, May 6, and Sunday, May 7
Fee: $100*
Place: Room 207, Dayton Exhibition Center
Time: 8:30 AM-4:30 PM Saturday
8:30 AM-3 PM Sunday
Sponsor: OSMA Committee on Scientific Work
Course Director: *Robert E. Potts, Ph.D.,* Director, Medical Audio-Visual and Television Center, Ohio State University
Course Description: Provide an overview of the systems approach for designing and testing self-instructional materials before actual production. Provide practice in designing a self-instructional unit in the participant's specialty area. Participants will develop instructional objectives, develop a testing plan and materials, list instructional events, produce a storyboard, and conduct peer reviews

DIALOGUE PRESENTATIONS

CME Hours: 1 Category 1 (each presentation)
Date: Tuesday, May 9
Place: Exhibit Floor, Dayton Exhibition Center
Sponsor: OSMA Committee on Scientific Work, in cooperation with the Pfizer Laboratories and Roerig Division of Pfizer Pharmaceuticals
Course Director: *Richard A. Waddell,* Manager, Pharmaceutical Exhibits, Pfizer Pharmaceuticals

Schedule

9 AM-10 AM Stress and Depression— Joseph Talley, M.D., Assistant Clinical Professor, Department of Family Practice, University of North Carolina, Durham

11 AM-12 NOON Use of Major Tranquilizers in Office Practice— John Crayton, M.D., Assistant Professor of Psychiatry, Department of Psychiatry, University of Chicago, Chicago, Illinois

1-2 PM Problems in Diabetic Management— T. S. Danowski, M.D., Clinical Professor of Medicine, University of Pittsburgh School of Medicine; and Director of Medicine, Shadyside Hospital, Pittsburgh, Pennsylvania

3-4 PM Management of the Hypertensive Patient— Donald G. Vidt, M.D., Head, Clinical Section, Department of Hypertension and Nephrology, Cleveland Clinic Foundation, Cleveland

LEGISLATIVE UPDATE

Date: Monday, May 8
Place: Assembly Hall, Dayton Exhibition Center
Time: 1:30-3 PM
Sponsor: OSMA Department of State Legislation
Course Director: *D. Brent Mulgrew, Esq.,* Director, OSMA Department of State Legislation
Faculty: Representative Larry H. Christman, Englewood; Senator Tony P. Hall, Kettering; Senator Michael J. Maloney, Cincinnati; and Representative Norman A. Murdock, Cincinnati
Program Description: This open forum is designed for physicians and spouses alike. Emphasis will be placed on current legislative issues of particular interest to the medical community. In addition, legislators will speak on the importance of grassroots contacts. Physicians and their spouses will learn how they can affect the legislative process by being both resource persons on medical matters and by participating in issues other than those directly affecting organized medicine.

MEDICAL WRITING WORKSHOP

CME Hours: 6 Category I
Date: Saturday, May 6, and Sunday, May 7
Fee: $60*
Place: Rms. 205 & 206, Dayton Exhibition Center
Time: 1-4 PM Saturday, 9 AM-12 Noon Sunday
Sponsor: OSMA Committee on Scientific Work
Course Directors: *Byron T. Scott, Ph.D.,* Associate Professor and Director, Magazine Sequence, Ohio University School of Journalism, College of Communications; former Editor, *Today's Health*

Barbara G. Cox, Manager of Biomedical Publications, Ross Laboratories; former Coordinator, Program Developer, Writer-Producer, and Medical Communications Specialist, Cancer Rehabilitation Programs, Mayo Comprehensive Cancer Center

Course Description: Parts of the scientific paper will be discussed: how to organize and to develop a manuscript, and how to prepare a paper for submission to a medical journal. In addition, common abuses of the language, especially as they appear in the scientific literature, will be reviewed. Participants will do exercises in the composition of concise sentences that convey meaning clearly to the reader. The editor-author relationships will also be explored. The workshop will consist of brief talks by the course directors, structured exercises, group discussions, and question-and-answer sessions.

NEGOTIATIONS

CME Hours: 14 Category I
Fee: $140*
Date: Saturday, May 6, & Sunday, May 7
Place: Room 204, Dayton Exhibition Center
Time: 8:30 AM-5 PM Saturday
8 AM-4 PM Sunday
Sponsor: OSMA Committee on Scientific Work
Course Directors: *Vincent S. Flowers, Ph.D.,* Center for Values Research, Dallas, Texas

J. Paige Clousson, Esq., Director, AMA Department of Negotiations

Course Description: Designed to introduce participant to the basics. Will show how to use assertiveness, trade-off statements, and a workable compromise. Will enable participant to choose the negotiating style that best fits his personality or emotional makeup.

Specialty Section Programs

ALLERGY AND IMMUNOLOGY

CME Hours: 3 Category I
Date: Wednesday, May 10
Place: Room 203, Dayton Exhibition Center
Time: 8:30 AM-12:15 PM
Sponsor: OSMA Section on Allergy and Ohio Society of Allergy and Immunology.
Presiding Officer: *Joseph E. Ghory, M.D.,* Cincinnati, President, Ohio Soeiety of Allergy and Immunology
Course Director: *Richard Krumholz, M.D.,* Dayton,

(continued on next page)

Specialty Section Programs *(continued)*

Program Chairman, Section on Allergy and Ohio Society of Allergy and Immunology

Schedule

8:30 AM Penicillin Allergy— Lawrence Sweet, M.D., Allergy Division, Henry Ford Hospital, Detroit, Michigan

9:30 AM Aspirin Hypersensitivity— Max Samter, M.D., University of Illinois, Chicago

10:30 AM Break

10:45 AM Hypersensitivity Pneumonitis— Jordan Fink, M.D., Professor of Medicine, Director of Division, Chief of Allergy Section, Medical College of Wisconsin

11:30 AM Panel Discussion— Doctors Sweet, Samter, and Fink. Dr. Krumholz, Moderator

12:30 PM Luncheon, Montgomery Room, Sheraton

ANESTHESIOLOGY

CME Hours: 3 Category I
Date: Wednesday, May 10
Place: Room 202, Dayton Exhibition Center
Time: 1:30-4:30 PM
Sponsor: OSMA Section on Anesthesiology and Ohio Society of Anesthesiologists

Course Director: *Douglas W. Eastwood, M.D.,* Program Chairman, Cleveland, Ohio Society of Anesthesiologists

Schedule

1:30 PM Anesthesia and the Patient on Chronic Medications— R. Bryan Roberts, M.D., Professor and Chairman, Department of Anesthesiology, Wright State University School of Medicine, Dayton

2:30 PM Drug Interactions and Anesthesia— John O. Lindower, M.D., Ph.D., Professor and Chairman, Department of Pharmacology, Wright State University School of Medicine, Dayton

3:30 PM Panel Discussion— What Effects From Which Drugs?— Doctors Roberts and Lindower

CHEST PHYSICIANS

CME Hours: 5 Category I
Topic: Symposium on Valvular Heart Disease—1978
Date: Monday, May 8
Place: Room 302, Dayton Exhibition Center
Time: 9 AM-5 PM
Sponsor: Ohio Chapter, American College of Chest Physicians

Course Director: *Siavosh Bozorgi, M.D.,* Dayton, Program Chairman, Ohio Chapter, American College of Chest Physicians

Schedule

9 AM Cardiac Catheterization in Diagnosis of Valvular Heart Disease: New Concepts—Paul W. Grunenwald, M.D., Associate Director, Cardiac Laboratory, Miami Valley Hospital; Associate Clinical Professor and Co-Director of Cardiology, Wright State University School of Medicine, Dayton

9:30 AM Valvular Heart Disease in Children: Diagnosis and Management— Dwight T. Tuuri, M.D., Pediatric Cardiologist; Associate Clinical Professor of Medicine, Wright State University School of Medicine, Dayton, and University of Cincinnati School of Medicine, Cincinnati

10 AM Coffee Break

10:30 AM Today's View of Aortic Valvular Disease: Medical vs Surgical Management— Richard P. Lewis, M.D., Professor of Medicine, Department of Medicine, Division of Cardiology, Ohio State University College of Medicine, Columbus

11 AM Valvular Heart Disease and Rheumatic Fever: Prevention, Treatment, Long-term Follow-up— Enayatollah Tabesh, M.D., Good Samaritan Hospital; Associate Clinical Professor of Medicine, Wright State University School of Medicine, Dayton

11:30 AM Combined Valvular and Coronary Heart Disease: Management, Prognosis, Results— Earl K. Shirey, M.D., Director, Cardiac Catheterization Laboratory, Cleveland Clinic, Cleveland

12 NOON Luncheon, Van Cleve II Room, Stouffers

1:30 PM Echocardiography in Diagnosis of Valvular Heart Disease— C. David Joffe, M.D., Good Samaritan Hospital, Dayton

2 PM Prosthetic Valves: Evaluation, Choices, Surgical Technique (Movie)— Siavosh Bozorgi, M.D., Good Samaritan and Kettering Memorial Hospitals; Assistant Clinical Professor of Surgery, Wright State University School of Medicine, Dayton

2:45 PM Anticoagulation and Valvular Heart Disease: Indications, Contraindications, What Is Right?— Richard P. Lewis, M.D., Columbus

3:15 PM Coffee Break

3:45 PM ECG, Vectocardiogram, Exercise Testing in Diagnosis of Valvular Heart Disease— Sylvan L. Weinberg, M.D., Director, Coronary Care Unit, Good Samaritan Hospital; Clinical Professor of Medicine, Wright State University School of Medicine, Dayton; Editor, *Heart and Lung*

4:15 PM Panel Discussion— Doctors Grunenwald, Joffe, Lewis, Shirey, Tabesh, Tuuri, and Bozorgi; and Stuart M. Denmark, M.D., President, Ohio Chapter, American College of Chest Physicians; Good Samaritan and Kettering Memorial Hospitals, St. Elizabeth Medical Center; Associate Clinical Professor of Surgery, Wright State University School of Medicine, Dayton; Chin Woo Imm, M.D., Director, Cardiovascular Laboratory and Chief, Department of Internal Medicine, Good Samaritan Hospital; Assistant Clinical Professor of Medicine, Wright State University School of Medicine, Dayton. Dr. Weinberg, Moderator

COLON AND RECTAL SURGERY

CME Hours: 3 Category I
Date: Wednesday, May 10
Place: Room 204, Dayton Exhibition Center
Time: 1:30-4:30 PM
Sponsor: Section on Colon and Rectal Surgery
Course Director: *William R. C. Stewart, M.D.,* Columbus

Schedule

1:30 PM Surgical Treatment of Low-Lying Rectal Neoplasms— Panelists: Victor W. Fazio, M.D., Cleveland; Eduardo Camacho, M.D., Guadalajara, Jalisco, Mexico; Ralph Samson, M.D., Columbus; and Patrick Hagihara, M.D., Lexington, Kentucky
2:55 PM Break
3:10 PM Rectal Pain: Evaluation, Diagnosis, and Treatment— Panelists: J. M. McIntyre, M.D., Indianapolis, Indiana; Jack D. Selzer, M.D., Cincinnati; Charles Hamilton, M.D., Columbus; and Carlos Andarsio, M.D., Springfield

DERMATOLOGY

CME Hours: 6 Category I
Topic: Dermatology for the Non-Dermatologist
Fee: $60*
Date: Monday, May 8
Place: Room 204, Dayton Exhibition Center
Time: 9 AM-5 PM
Sponsor: Section on Dermatology
Course Director: *Wilma F. Bergfeld, M.D.,* Head, Section of Dermatopathology, Cleveland Clinic, Cleveland

Schedule

9 AM Introduction— Dr. Bergfeld: Dermatologic Quiz
9:15 AM Diagnosis of Premalignant and Malignant Skin Disorders— Philip L. Bailin, M.D., Head, Department of Dermatology, Cleveland Clinic, Cleveland
10 AM Question-and-Answer Period
10:15 AM Acne Vulgaris: What's It All About and How to Treat It— Leo J. Miedler, M.D., Clinical Assistant Professor, Medical College of Ohio, Toledo
10:45 AM Question-and-Answer Period
11 AM Dermatologic Shorts
12 NOON Luncheon
1:30 PM Skin Punch Biopsy Movie— Dr. Bergfeld
1:45 PM Drug Eruptions: Recognition and Treatment — Richard Belcher, M.D., Professor & Head, Department of Dermatology, Medical College of Ohio, Toledo
2:30 PM Question-and-Answer Period
2:45 PM Cutaneous Manifestations of Systemic Disease— Dr. Bergfeld
3:15 PM Question-and-Answer Period
3:30 PM Dermatologic Quiz
4:15 PM Dermatologic Quickies

EMERGENCY MEDICINE

CME Hours: 3 Category I
Topic: The Use of Simulated Patients in Emergency Medicine
Date: Tuesday, May 9
Place: Room 204, Dayton Exhibition Center
Time: 1:30-4:30 PM
Sponsors: Sections on Emergency Medicine, Directors of Medical Education, and the Ohio Committee on Trauma, A.C.S.
Course Director: *George F. Millay, M.D.,* Assistant Director of Emergency Services, Riverside Methodist Hospital, Columbus
Guest Speaker: *James R. MacKenzie, M.D.,* McMasters University, Department of Surgery, Hamilton, Ontario, Canada
Course Description: Simulated patients will be used to demonstrate signs and symptoms of acute emergencies. A wide range of clinical syndromes will be presented. Audiences will be evaluated as to physician/nurse response to emergency syndromes. Audience will also be taught how to simulate a specific emergency

INTERNAL MEDICINE

CME Hours: 3 Category I
Date: Tuesday, May 9
Place: Room 202, Dayton Exhibition Center
Time: 9 AM-12 Noon
Sponsor: OSMA Section on Internal Medicine and Ohio Society of Internal Medicine
Presiding Officer: *Edward S. Schneir, M.D.,* Akron, President, Ohio Society of Internal Medicine
Course Director: *William J. Marshall, M.D.,* Dayton, Program Chairman, OSMA Section and Ohio Society of Internal Medicine
Faculty: Barbara Beeler, M.D., Department of Medicine, Wright State University College of Medicine, Dayton

Richard P. Lewis, M.D., Professor of Medicine, Department of Medicine, Division of Cardiology, Ohio State University College of Medicine, Columbus

William J. Marshall, M.D., Dayton

NEUROSURGERY

CME Hours: 6 Category I
Topic: Current Status of Pituitary Surgery
Date: Tuesday, May 9
Place: Rms. 304 & 305, Dayton Exhibition Center
Time: 9 AM-5 PM
Sponsor: Section on Neurosurgery and Ohio State Neurological Society
Course Directors: *William E. Hunt, M.D.,* Columbus; and *John Tew, M.D.,* Cincinnati

(continued on next page)

Schedule

9 AM Neuroradiology of Sellar and Parasellar Lesions — John Johnson, M.D., Associate Professor, Department of Radiology, Ohio State University, Columbus

9:30 AM Pathology of Sellar Lesions— Leopold Liss, M.D., Professor of Neuropathology, Ohio State University, Columbus

10 AM Coffee Break

10:30 AM Medical Aspects of Pituitary Disease— William Malarky, M.D., Associate Professor, Division of Endocrinology, Ohio State University, Columbus

11 AM Surgical Approach: Pituitary Lesions— George T. Tindall, M.D., Professor of Surgery and Chief of Neurosurgery, Emory University School of Medicine, Atlanta, Georgia

11:30 AM Panel Discussion— Doctors Johnson, Liss, Malarky, Tindall. Dr. Hunt, Moderator

12:30-2 PM Luncheon, King Cole Restaurant, Winters National Bank Building, Main and 2nd Streets

2 PM Fractures of the Thoracolumbar Spine: Diagnosis and Treatment— Thomas G. Saul, M.D.; Frank H. Mayfield, M.D.; Stewart B. Dunsker, M.D., Cincinnati

2:15 PM Treatment of Lumbar Compression Fractures With Neurologic Deficit— Richard C. Dewey, M.D.; James E. Barnes, M.D.; Henry H. Gary, Jr., M.D.; Dr. Hunt, Columbus

2:30 PM Cervical Discography— Robert J. Brocker, M.D., Youngstown

2:45 PM Central Cord Syndrome Following Mobilization After Decompression— Donald F. Dohn, M.D.; Jay Levy, M.D.; Russell W. Hardy, M.D., Cleveland

3 PM Dissecting Aneurysms of the Carotid Artery— Dr. Tew, A. Lee Greiner, M.D., Cincinnati

3:15 PM Giant Aneurysms of the Transverse Cerebral Fissure— Carole A. Miller, M.D.; Dr. Hunt, Columbus

3:30 PM Intravascular Navigation: Applications in Neurosurgery— Dr. Tew

3:45 PM Central Nervous System Germinoma: With a Report of Ten Cases From the Cleveland Clinic— F. G. McMurry, M.D., Cleveland Clinic, Cleveland

4 PM Intermission

4:15 PM Business Meeting

OPHTHALMOLOGY

CME Hours: 2½ Category I
Date: Tuesday, May 9
Place: Room 302, Dayton Exhibition Center
Time: 2-4:30 PM
Sponsor: Section on Ophthalmology and Ohio Ophthalmological Society

Course Director: *John D. Bullock, M.D.,* Dayton, Secretary, Section on Ophthalmology

Schedule

2 PM Intubation of the Lacrimal Drainage System: Technique and Indications— John Burns, M.D., Columbus

2:15 PM Fascia Lata in Enucleation Surgery— Mark Levine, M.D., Cleveland Heights

2:30 PM Diagnosis and Treatment of Orbital Cellulitis — Allison J. Berlin, Jr., M.D., Cleveland

2:45 PM Surgery of the Lacrimal Drainage System— James E. Bennett, M.D., Cleveland

3 PM Techniques of Eyelid Reconstruction— John D. Bullock, M.D., Dayton

3:30 PM Computerized Transaxial Tomography in Ophthalmology— Robert R. Waller, M.D., Rochester, Minnesota

OTOLARYNGOLOGY

CME Hours: 4 Category I
Date: Monday, May 8
Place: Room 202, Dayton Exhibition Center
Time: 9 AM-4 PM
Sponsor: OSMA Section on Otolaryngology and Ohio Society of Otolaryngology
Presiding Officer: *E. L. Hendershot, M.D.,* Cleveland, President, Ohio Society of Otolaryngology and Chairman, Section on Otolaryngology

Schedule

9 AM Management of Melanoma of the Head and Neck— Ronald Hamaker, M.D., Indianapolis, Indiana

10 AM Break

10:30 AM Surgical Management of Thyroid Disease— Dr. Hamaker

12 NOON Luncheon— Van Cleve II, Stouffers

1:30 PM Management of Vertigo— Jack Pulec, M.D., Los Angeles, California

2:30 PM Break

3 PM Management of Vertigo (continued)

PATHOLOGY

CME Hours: 4 Category I
Topic: Pathology of the Thyroid
Date: Tuesday, May 9
Place: Room 203, Dayton Exhibition Center
Time: 9 AM-4:15 PM
Sponsor: Section on Pathology and the Ohio Society of Pathologists
Course Director: *Joseph F. Meara, M.D.,* Columbus, Program Chairman, Section on Pathology and Ohio Society of Pathologists

Schedule

9 AM Welcome— Ralph J. Johansmann, M.D., Columbus, President, Ohio Society of Pathologists

9:05 AM The Parafollicular Cells of the Thyroid— Hari M. Sharma, M.D., Associate Professor of Pathology, Ohio State University

9:30 AM Therapy and Prognosis of Thyroid Carcinoma— Ernest L. Mazzaferri, M.D., Professor of Endocrinology, Department of Medicine, Ohio State University

10 AM Break

10:15 AM Surgical Perspective in Carcinoma of the Thyroid— Speaker to be Announced

10:45 AM Panel Discussion— Classification and Therapy of Thyroid Neoplasms— Doctor Mazzaferri and J. Beach Hazard, M.D., and a third panelist

11:45 AM Business Meeting

12:45 PM Luncheon

1:30 PM Thyroid Function and Carcinoma, Experimental Results— Sharad D. Deodhar, M.D., Ph.D., Head, Department of Immunopathology, Cleveland Clinic, Cleveland

2 PM Slide Seminar: Diseases of the Thyroid— J. Beach Hazard, M.D., Emeritus Consultant in Pathology, Cleveland Clinic; formerly Head, Division of Pathology, Cleveland Clinic, Cleveland

3 PM Break

3:15 PM Continuation of Slide Seminar

PHYSICAL MEDICINE AND REHABILITATION

CME Hours: 3 Category I
Date: Monday, May 8
Place: Room 203, Dayton Exhibition Center
Time: 1:30-4:30 PM
Sponsor: OSMA Section on Physical Medicine and Rehabilitation and Ohio Society of Physical Medicine and Rehabilitation

Course Director: *John A. Burkhart, M.D.,* Program Chairman, Section on Physical Medicine and Rehabilitation, Columbus

Faculty: *Jack H. Petajan, M.D., Ph.D.,* Department of Neurology, University of Utah College of Medicine, Salt Lake City

David H. Wiechers, M.D., Department of Physical Medicine, Ohio State University College of Medicine, Columbus

PLASTIC SURGERY

CME Hours: 3 Category I
Time: Reconstruction of Breast After Radical Mastectomy
Date: Wednesday, May 10
Place: Room 202, Dayton Exhibition Center
Time: 9 AM-12 Noon
Sponsor: OSMA Section on Plastic Surgery and Ohio Society for Plastic and Reconstructive Surgeons

Course Co-Directors: *Philip A. Weisman, M.D.,* Associate Clinical Professor Surgery, Wright State University School of Medicine, Dayton; and Program Chairman, Section on Plastic Surgery

Ramchandra Ramnath, M.D., Associate Clinical Professor of Surgery, Wright State University School of Medicine, Dayton

Schedule

9 AM Introduction— Dr. Ramnath

Moderator: *John D. Desprez, M.D.,* Associate Clinical Professor of Surgery, Case Western Reserve University School of Medicine, Cleveland; President, Ohio Society of Plastic and Reconstructive Surgeons; and Chairman, Section on Plastic Surgery

9:10 AM Current Surgical Treatment for Carcinoma of the Breast— Dan W. Elliott, M.D., Chairman— Department of Surgery, Wright State University School of Medicine, Dayton

9:22 AM The Pathologist's Point of View— Ludolph H. van der Hoeven, M.D., Clinical Professor of Pathology, Wright State University School of Medicine; Director, Department of Laboratory Medicine, Good Samaritan Hospital, Dayton

9:32 AM Indications and Contraindications to Reconstruction— Lois M. Breidenbach, M.D., Section of Plastic Surgery, Good Samaritan Hospital, Dayton

9:42 AM The Patient's Point of View— Mrs. Mary F. Moran, Chairperson and Volunteer, Montgomery County Division of "Reach to Recovery" (an international society associated with the American Cancer Society)

9:52 AM The Mound— Henry W. Neale, M.D., Associate Professor of Surgery, University of Cincinnati School of Medicine; Director, Division of Plastic, Reconstructive, and Hand Surgery, Cincinnati

10:02 AM Reconstruction After Radiation Treatment —Dr. Desprez

10:12 AM Recess

Moderator: *Shattuck W. Hartwell, Jr., M.D.,* Senior Staff, Section of Plastic Surgery, Cleveland Clinic Hospital, Cleveland

10:45 AM The Nipple-Areola Complex— John C. Kelleher, M.D., Associate Clinical Professor of Surgery, Medical College of Ohio, Toledo

10:55 AM The Other Breast— Lester R. Mohler, M.D., Assistant Clinical Professor of Surgery, Ohio State University Hospitals, Columbus

11:05 AM Secondary Scarring and Deformity— Thomas C. Graul, M.D., Associate Clinical Professor of Surgery, Wright State University School of Medicine; Director, Plastic Surgery Residency, Kettering Memorial Hospital, Dayton

11:15 AM What Will It Cost and Who Will Pay— Robert P. Stafford, M.D., Director of Medical Services, Midwestern Head Office, Metropolitan Life Insurance Company, Dayton

11:25 AM Long-term Expectations— Ronald B. Berggren, M.D., Professor and Director, Division of Plastic Surgery, Ohio State University Hospitals, Columbus

(continued on next page)

Specialty Section Programs *(continued)*

11:35 AM Discussion
11:50 AM Summation— Dr. Hartwell
12:15 AM Luncheon, Dayton Room, Sheraton

PSYCHIATRY

CME Hours: 5 Category I
Topic: Minor Tranquilizers and Anxiety
Date: Sunday, May 7
Place: Kettering Room, Sheraton
Time: 9 AM-3:30 PM
Sponsor: Section on Psychiatry and Neurology, Ohio Psychiatric Association and Internal Medicine Section
Course Director: *Barry Blackwell, M.D.,* Professor and Chairman, Department of Psychiatry, Professor, Department of Pharmacology, Wright State University School of Medicine, Dayton

Schedule

9 AM Pharmacology of Benzodiazepines— John O. Lindower, M.D., Ph.D., Professor and Chairman, Department of Pharmacology, Wright State University School of Medicine, Dayton
9:40 AM Discussion
9:50 AM Clinical Use of Benzodiazepines— Karl Rickles, M.D., Professor of Psychiatry, University of Pennsylvania, Philadelphia
10:30 AM Discussion
10:40 AM Coffee Break
11:10 AM Sociopharmacology of Benzodiazepines— Dr. Blackwell
11:50 AM Discussion
12 NOON-1:15 PM Luncheon, Montgomery Room, Sheraton
1:15 PM Rotating workshops with guest lecturers
2 PM Rotating workshops with guest lecturers
2:45 PM Rotating workshops with guest lecturers

RADIOLOGY

CME Hours: 2 Category I
Topic: Selected Topics in Radiology for the Primary Care Physician
Date: Wednesday, May 10
Place: Rms. 304 & 305, Dayton Exhibition Center
Time: 2-4 PM
Sponsor: OSMA Section on Radiology
Course Director: *D. Kiefer Campbell, M.D.,* Dayton, Secretary, Section on Radiology
Moderator: *Konrad F. Kircher, M.D.,* Attending Radiologist and Chief of Staff, St. Elizabeth Hospital; Associate Clinical Professor of Radiology, Wright State University Medical School, Dayton; Chairman, Section on Radiology

Schedule

2 PM Radiological Findings in Pulmonary Embolism— Burton G. Must, Jr., M.D., and Tomas S. Garnica, M.D., Dayton
2:30 PM CAT Scanning— Jerome Andrews, M.D., Director, Department of Radiology, Kettering Memorial Hospital; Assistant Clinical Professor of Radiology, Wright State University School of Medicine
3 PM The Pneumoperitoneum— D. Kiefer Campbell, M.D., Attending Radiologist, Good Samaritan Hospital; Assistant Clinical Professor of Radiology, Wright State University School of Medicine
3:30 PM Ultrasound of the Abdomen and Pelvis— Felix Garfunkel, M.D., Chief of Radiology, Greene Memorial Hospital, Xenia; Associate Clinical Professor of Radiology, Wright State University School of Medicine

RHEUMATOLOGY

CME Hours: 2½ Category I
Topic: Rheumatoid Arthritis
Date: Monday, May 8
Place: Room 207, Dayton Exhibition Center
Time: 1:30-4 PM
Sponsor: OSMA Section on Rheumatology and the Ohio Rheumatism Society
Course Director: *Ron Whisler, M.D.,* Program Chairman, Section on Rheumatology and Ohio Rheumatism Society

Schedule

1:30 PM Clinical Diagnosis of Rheumatoid Arthritis— Raymond J. Scheetz, Jr., M.D., Cleveland
2 PM Extra-Articular Complications of Rheumatoid Arthritis— Kenneth Brandt, M.D., University of Indiana, Indianapolis
2:30 PM Break
3 PM Diagnosis and Interpretation of Laboratory Tests in Rheumatic Diseases— Evelyn Hess, M.D., Cincinnati
3:30 PM Treatment of Rheumatoid Arthritis— Norman Rothermich, M.D., Columbus

SPORTS MEDICINE & FAMILY PRACTICE

CME Hours: 2½ Category I
Topic: Physical Condition and Fitness in Sports Medicine
Date: Tuesday, May 9
Place: Room 303, Dayton Exhibition Center
Time: 9 AM-12 Noon
Sponsor: Section on Sports Medicine, Section on General Practice, and Ohio Academy of Family Physicians
Course Director: *Robert K. Finley, Jr., M.D.,* Dayton, Program Chairman, Section on Sports Medicine

Schedule

9 AM Nautilus as a Means of Conditioning— William Donahue, D.O., and Chris Ward

9:30 AM The Run for Your Life Program— Lou Cox, Director, YMCA Conditioning Program
9:50 AM Questions
10 AM Procedures in Conditioning for Collegiate Football— Les Bodner, M.D., Team Physician, University of Notre Dame, South Bend, Indiana
10:30 AM Break
11 AM Physical Conditioning to Prevent Athletic Injuries— Robert J. Murphy, M.D., Team Physician, Ohio State University, Columbus
11:20 AM Questions
11:30 AM Methods of Conditioning for High School Football— Rusty Clifford, Head Coach, Fairmont East High School, Dayton
11:50 AM Questions
12:15 PM Luncheon, Dayton Room, Stouffers
1:30 PM Meeting of Section on General Practice, Room 303, Dayton Exhibition Center

Tours

DAYTON MEDICAL FACILITIES VISITATION

Date: Monday, May 8
Time: AM (Check OSMA Registration Desk for departure schedule)
Transportation: Bus
Tour Description: The purpose of the visitation is a "show and tell" event arranged to acquaint visiting physicians with the unique qualities of each facility. It is necessary that all participants in the visitation check the appropriate box on the registration form. Buses will be provided by the OSMA.
Facilities to be Toured:

Wright Patterson Air Force Base
Hyperbaric Therapy
Miami Valley Hospital
High-Risk Pregnancy Center
Cancer Treatment Areas
Dialysis (Kidney) Regional HEW
Emergency Burn Treatment Center
Kettering Hospital
Computerized EKG
Cardiac Education
St. Elizabeth Hospital
Family Practice Department
Physician Medicine and Rehabilitation Department
Good Samaritan Hospital
Central Processing Department
Interstitial Structure of Hospital
Veterans Administration Hospital
Electron Microscope
Bio-Feedback Equipment
Speech Rehabilitation Department
Old Library— Archives of Military Medicine
Children's Hospital
Newborn Intensive Care Unit
Young Adult (Adolescent) Unit
Outpatient and Day Surgery Unit

WRIGHT STATE UNIVERSITY SCHOOL OF MEDICINE TOUR

Date: Monday, May 8
Time: AM (Check OSMA Registration Desk for departure schedule)
Transportation: Bus
Tour Description: Check appropriate box on registration form if plan to tour. Buses will be provided by Wright State

U.S. AIR FORCE MUSEUM TOUR

Date: Monday, May 8
Time: PM (Check OSMA Registration Desk for departure schedule)
Transportation: Bus
Tour Description: Arrangements have been made with the museum to extend visitation hours. OSMA will furnish buses at no charge. However, participants in the tour will be responsible for their own admission fee. Check appropriate box on registration form to take part in tour

Support OSMA . . .

Pay Your 1978 Dues

Have you paid your medical association dues? If not, this may be the last *Journal* you receive. In May, our mailing list will be cleared of 1977 members who have not renewed in 1978.

The Journal is only one of the benefits of OSMA membership. As a member, you also receive the Association's other publications, including the *OSMAgram* and *Synergy*. These publications highlight the activities planned for members, including continuing education courses, tours, and special programs. In addition, the Association offers a number of insurance programs and one for car leasing.

Equally as important but not as visible is the continued vigilance in support of our physician members in the Ohio Legislature, the U.S. Congress, government medical programs, and public opinion. The Association also is the physician's liaison to such groups as the Ohio State Medical Board and the Ohio State Department of Education, and the OSMA provides on-going personal communication with members through field representatives and membership services.

So, if your dues are not paid, why not write your check for $125 today. To ensure the unity that results from solid membership through county, state, and national support, include AMA dues of $250 in your check. Remember, the achievements of all three are to your advantage. Your support is essential.

What to See and Where to Eat in Dayton

Mrs. W. J. Marshall, Montgomery County Medical Auxiliary

Dayton is the birthplace of aviation, the cash register, and the automotive self-starter. It is well-known for refrigerators. And Wilbur and Orville Wright, Charles F. Kettering, and Governor James M. Cox called the city home.

City sights of special interest to the visitor include the following:

Benjamin Wegerzyn Garden Center

1301 Siebenthaler.

Greenhouses, landscapes, common and rare trees, shrubs, and flowers. Grounds open everyday. Greenhouses open 7:30 AM - 3:30 PM Monday through Friday. No admission charge.

Carillon Park

Route 25 South.

61-acre park. Site of museum buildings and historical exhibits. Also site of Deeds Carillon, 40-bell tower, one of Dayton's landmarks. Open from May 1 to Octover 31, 10 AM - 8:30 PM, Tuesday-Saturdays, 1-8:30 PM on Sunday. Closed Mondays except on holidays.

Courthouse Square

Courthouse built in 1850. One of finest examples of Greek Revival architecture in America. Open to the public.

Cox Arboretum

6733 Springboro Pike (Route 741).

Once a farm, now contains display of trees, shrubs, vines, and plants on 130 acres. Open to public 8 AM to dusk.

Dayton Art Institute

405 West Riverview.

Building is beautiful example of Italian Renaissance architecture. One of finest art collections in Midwest. Concerts, films, lectures, symposiums given here. Free admission to galleries. Open from noon to 5 PM Tuesday through Friday and also on Sunday; 9 AM to 5 PM on Saturday.

Dayton Museum of Natural History

2629 Ridge Avenue.

Exhibits on the natural history, geology, archaeology, and astronomy of the Miami Valley in particular as well as the world in general.

Hawthorn Hill

Harman and Park Avenue.

Not open to public, but if in the Oakwood area, drive by to see the magnificent home of the Wright Brothers.

Oregon Historic District

Twelve-square-block area bounded by Fifth Street, Wayne Avenue, Route 35, and Patterson Boulevard.

This neighborhood dates back to 1820 and was at one time Dayton's finest. Many of the stately old homes have been restored and others are in the process. Various arts and craft shops, antique shops, and restaurants are located in the area.

Paul Laurence Dunbar House

219 North Summit Street.

Home of famous Negro poet. Maintained by Ohio Historical Society. To arrange tours, call 263-7609, 263-6332, or 224-7061.

Sinclair Community College

444 West Third Street at Interstate 75.

Two-year college designed by architect Edward Durrell Stone. Career-oriented programs pursued by 9,000 students.

United States Air Force Museum

Springfield Pike on Wright-Patterson Air Force Base.

Dayton's best-known attraction, also Ohio's largest free tourist attraction. One-hundred and thirty aircraft and missiles may be seen there. Open 9 AM - 5 PM Monday through Friday; 10 AM - 6 PM Saturday through Sunday.

University of Dayton

300 College Park Drive.

Catholic institution with 6,000 students.

Wright State University

3640 Colonel Glenn Highway.

Ohio's newest state university; now includes a medical school. Enrollment 12,000.

Entertainment:

La Comedia Dinner Theatre: State Route 73. "Shenandoah" March 22 through May 28.

Dining:*

Alex's Continental Inn

125 Monarch Lane, Miamisburg. 866-2266.

American and European cuisine in rustic atmosphere. Closed Sunday.

(continued on page 241)

*Reservations suggested.

Make Your Hotel Reservations

for the

1978 OSMA Annual Meeting

DAYTON, OHIO MAY 6-10

STOUFFER'S DAYTON PLAZA HOTEL.....**5th and Jefferson Streets**
(OSMA Headquarters)

Single $27
Double $32

SHERATON DAYTON DOWNTOWN.....**21 S. Jefferson Street**
(OSMA Co-Headquarters)

Single $24
Double $30

RAMADA INN / Downtown.....**330 W. First Street**
(Auxiliary Headquarters)

Single $20
Double $25

HOLIDAY INN / Downtown.....**404 W. First Street**

Single $23
Double $31

All rates subject to change. If you plan to share a room, please indicate name of roommate.

HOTEL RESERVATION BLANK

(Mail to Hotel of Choice)

_____
(Name of Hotel)

_____ Dayton, Ohio
(Address)

Please reserve the following accommodations during the period of the Ohio State Medical Association Annual Meeting, May 6-10, 1978 (or for period indicated). (Note: In order to accommodate you, please make reservations by April 15, 1978.)

_____ Single Room

_____ Double Room

_____ Other Accommodations

Price Range_____ Guaranteed_____

No. of Persons_____ Arrival Date_____ Hour of Arrival_____ Departure Date_____

Name_____

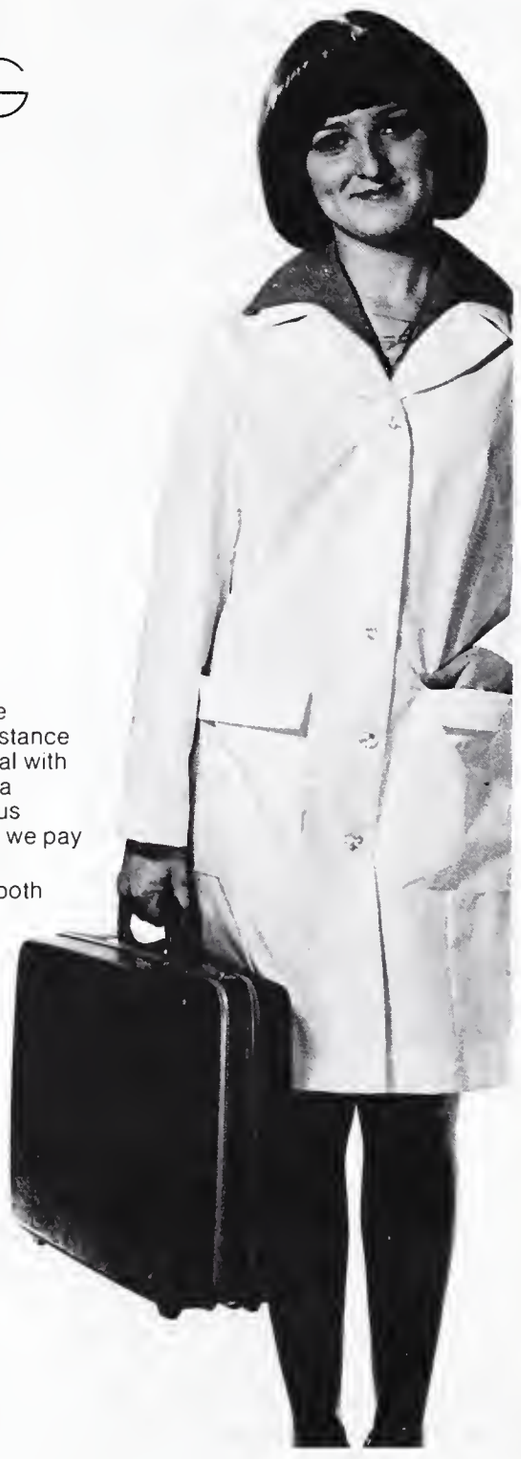
Address_____

City_____ State_____ Zip_____

PLEASE VERIFY MY RESERVATION

If Rate or Accommodation requested not available, next highest rate or accommodation will prevail.
Rooms will be held until 6 PM unless payment is guaranteed.

Your hospital's complete EEG laboratory!



Daneman Laboratories' space-age electronics technology and two long-distance telephone calls will provide your hospital with same-day EEG and ECHO readings by a qualified neurologist. Even instantaneous reports can be provided if needed. And we pay for the phone calls!

This service has wide benefits for both hospital and patient:

- Fully effective
- Safe and comfortable
- Professionally-administered
- Easily performed
- Inexpensive
- Fail-safe reporting procedures
- Already in operation nationwide

For a copy of our easy-to-understand, no-obligation proposal, please call or write Business Manager Jean Murphy.

Daneman Laboratories
P.O. Drawer 152, Gambier, OH 43022
Telephone. 614-427-4577

Annarino's Supper Club
2826 North Dixie Drive. 277-6934.
Italian food. Evening entertainment. Closed Sunday.

Anticoli's Italian Restaurant
3045 Salem Avenue. 277-2264.
Italian cuisine. Great lunch. Excellent filet mignon and Anticoli salad. Closed Monday.

Antonio's Italian & American Restaurant
28 W. Franklin, Centerville. 433-7441.
Italian cuisine. Warm, friendly atmosphere. Large menu selection, delicious lasagna. Closed Sunday and Monday.

Brawley's Family Restaurant
1875 Needmore Road. 890-3481.
Open 24 hours. Reasonable prices.

Brown Derby Lobster House
1911 N. Main. 276-9319.
Try two-pound lobster. Steaks.

Carillon Cafeteria
2611 S. Dixie. 299-9622.
Home-type cooking. Wide selection. Inexpensive. Pies are especially good. Quick service.

Chow's Garden Restaurant
4645 N. Main. 274-1720.
Chinese food. Large selection. Try chicken wings in oyster sauce.

Colony Club
2801 S. Dixie. 293-4135.
Large supper club with Dixieland band and dancing. Good food and service. Steaks, prime rib, seafood. Closed Sunday.

Cork and Cleaver
2501 S. Dixie Drive. 294-0157.
Attractive. Crab legs and steaks specialty. Salad bar. Open daily.

Crepe Escape
500 E. 5th Street. 223-2578.
Located in Oregon historic district. Crepes are specialty of course. Try avocado salad.

Grammer's German Village
101 Pine St. 222-3447.
Located in Oregon historic district. German specialties served in atmosphere of outdoor cafe in German village.

Grub Steak
1410 N. Main. 276-4193.
Royal ribs. Closed Sunday.

The Inn
4120 Far Hills. 299-5536.
Good marriage between European and American cuisine. Good food for either lunch or dinner. Chef will prepare special dinner with 24-hour notice. Closed Monday.

Jay's
225 E. 6th St.
Located in Oregon historic district. Shrimp and oyster bar.

Joe's is a Fish House
2221 Wagoner Ford Rd. 275-1912.
Fresh seafood. Try Mussells Russell.

King Cole
Winters Tower, Ground Floor. 222-6771.
Holiday Award restaurant. Delicious food in elegant surroundings. One of Dayton's best-known restaurants.

Ko Reo
320 North Broad, Fairborn. 879-1974.
Cantonese, Mandarin, Korean cuisine. Try Chop Chae.

Ming Tree
5611 North Dixie Drive. 278-7750.
Chinese cuisine. Try marinated, skewered ginger beef.

Neil's Heritage House
2189 S. Dixie. 298-8611.
Restaurant consists of large main dining room which features filet of sole, stuffed with crabmeat, and breaded pork tenderloin; and the Tenderloin Room, a more intimate atmosphere, where the mainstays are steaks and crab legs.

Oakwood Club
2414 Far Hills. 293-6973.
A favorite neighborhood restaurant of many. Serves steaks, chops, and the usual.

Peasant Stock Cobblestone Shops
Town & Country Shopping Center. Stroop & Shroyer Rd. 293-3900.
One of Dayton's newest. Very attractive and interesting decor. Good onion soup and "pommes frites." French country restaurant.

Peerless Mill Inn
319 S. 2nd St., Miamisburg. 866-5968.
Very rustic decor, warm atmosphere. All meals accompanied by corn fritters with hot maple syrup and hot loaves of bread. Closed Monday.

Peking Inn
101 W. Franklin, Centerville. 433-6676.
Mandarin cuisine. Try Lobster Szechuan, Moo Shoo pork.

Pine Club
1926 Brown St. 226-9064.
Best steak in town, some would even say in the whole world, but be prepared for a long, long wait. Very small and does not take reservations. You might consider coming at 5 PM since it opens at 4:30 PM and is busy from the start. For a side dish, do get the stewed tomatoes. Closed Sunday.

(continued on next page)

Scotch & Steak
2900 Wilmington Pike. 293-2177.
Serves steaks, prime rib, shish kabobs, crab legs, excellent salads. Closed Sundays.

Stouffer's Top of the Plaza
Fifth & Jefferson. 224-0800.
Good for Sunday brunch. Nice place to enjoy the lights of the city in the evening.

Stockyard's Inn
1065 Springfield. 254-3576.
Beef and king-size cocktails. Victorian decor.

Suttmiller's
850 N. Main. 461-5323.
Well-known Dayton supper club which features live big-name entertainment. Bavarian food. Closed Sundays.

T.G.I. Friday's
2022 Miamisburg-Centerville Rd. (Route 725). 435-4930.
Swinging atmosphere. Everyone seems to be having fun. Restaurant has an antique bar. Extensive menu, two favorites being the spinach salad with avocado and other goodies and the Irish coffee.

Totenko
2925 Miamisburg-Centerville Rd. (Route 725). across from Dayton Mall. 433-1242.
American, Oriental, Polynesian cuisine. Open seven days a week.

Tropics
1721 N. Main. 278-4241.
Long-time supper club provides South Seas atmosphere and nightly entertainment. Cantonese and American cuisine. Closed Sunday.

Yankee Tavern
8112 Yankee Rd. at Rt. 725. 433-0410.
Live entertainment Tuesday through Saturday. Closed Sunday. Has recently added an oyster bar.

Shopping:

Beauty Shops:

Downtown
- Elder-Beerman
- Rikes

Department Stores:

- Elder-Beerman
- Metropolitan
- Rikes

Men's Specialty Shops:

- Walker's— 135 North Main
- B.M.Y. Men's Shop, Inc.— One First National Plaza
- D. H. Peer, Ltd.— 10 West Monument

Women's Specialty Shops:

Downtown
- Ross McClure's Zapoleon— One First National Plaza
- Dale Fashions— First & Ludlow
- Donenfeld's— 17 S. Main Street
- Baynham Shoes— 143 N. Main Street

North of Town
- O'Connell's of Dayton— 1944 N. Main Street

South of Town
- Hilltop House— 2501 Far Hills
- Clothes Loft— 2308 Far Hills
- Carriage Trade— 3100 Far Hills
- Village Peddlar— 5529 Far Hills
- Bonnetta's— 6328 Far Hills

Good shopping at both Dayton Mall, south of town, and Salem Mall, north of town.



THE WENDT-BRISTOL COMPANY
1159 DUBLIN ROAD
COLUMBUS, OHIO 43215
614/486-9411

MEDICAL/SURGICAL PRODUCTS
LABORATORY PRODUCTS
SPECIALTY PRODUCTS
PHARMACEUTICALS
PATIENT AIDS
INSTRUMENTS
FURNITURE



COLACE prevents hard, dry stools common to constipation . . . and does it without laxative stimulation. COLACE assists peristalsis by simply letting intestinal water permeate stools.

COLACE helps to prevent painful straining at stool—particularly important in patients with delicate anorectal disorders. Safe and non-habit forming . . . COLACE, the simple water way to ease constipation from infancy to old age.

Simple drops of water help make COLACE® the most widely used stool softener.

COLACE®
dioctyl sodium sulfosuccinate

Mead Johnson
PHARMACEUTICAL DIVISION

This asthmatic isn't worried about his



next breath...

he's active
he's effectively
maintained on

QUIBRON®

Each capsule ar tablespaanful (15 ml) elixir contains theaphylline (anhydrous) 150 mg and glyceryl guaiacalate (guaifenesin) 90 mg. Elixir: alcahal 15%

high theophylline for effective around-the-clock therapy

Quibron may give the asthmatic up to eight hours of bronchodilation with each dose and provides the high dosages of theophylline which are now believed necessary to keep patients free of acute attacks and chronic wheezing.

100% free theophylline

Quibron helps achieve high serum theophylline levels with minimal dosage volume...delivers 100% free theophylline in comparison to many other compounds which contain from 47% to 91% effective theophylline.

individualized theophylline dosage schedule

Today's more efficient usage of theophylline includes individualizing dosage and monitoring serum theophylline levels. The usual recommended dosages of Quibron are: Adults—1 to 2 capsules or tablespoonfuls every 6 to 8 hours; dosage may be cautiously adjusted upward when necessary to a maximum of 2000 mg theophylline per 24 hours. Children under 12—4 to 6 mg theophylline per kg/body weight every 6 to 8 hours; dosage may be cautiously adjusted up to 9 or 10 mg/kg every 6 hours.

Now, for the asthmatic who requires high-dose theophylline therapy for therapeutic serum concentrations

Mead Johnson Pharmaceutical Division announces

QUIBRON®-300

Eoch copsule contoins 300 mg theophylline (onhydrous) and 180 mg glyceryl guoiocolote (guoifenesin)

For Brief Summary, please see the last page of this advertisement.

QUIBRON®-300

Each capsule contains 300 mg theophylline (anhydrous) and 180 mg glyceryl guaiacolate (guaifenesin)

The new high-dose theophylline capsule... for dependable theophylline therapy when products of lower dosage do not adequately control asthma symptoms.

Specially formulated

...for optimal efficacy

Quibron-300 is appropriate therapy for asthma patients whose symptoms are not adequately controlled on lower doses of theophylline, particularly for patients whose theophylline dosage has been adjusted upward to achieve therapeutic serum levels. In one study,[1] an average peak increase in FEV_1 of 35% was demonstrated after a single dose equivalent to one Quibron-300 capsule, and significant improvement in this pulmonary function lasted for nearly eight hours after administration.

...for optimal predictability

One Quibron-300 capsule q6-8h yields therapeutic serum levels (10-20 mcg/ml) in many adults. With a single dose, more than 75% of patients achieved serum levels potentially providing clinical benefit (5-15 mcg/ml). Half-life of theophylline varies widely from patient to patient, making monitoring of theophylline therapy important. Patient response may be monitored clinically if blood levels are not available as long as dosage does not exceed 1200 mg in 24 hours for adults.

...for optimal dosage convenience

The simple, convenient dosage of new Quibron-300—one capsule every six to eight hours—makes it easy for patients to comply with high-dose regimens often required to achieve therapeutic serum levels. Quibron-300 capsules may provide maximum therapeutic value with maximum convenience. In fact, the switch from a low-dose to a high-dose regimen may be accomplished by merely switching capsules, by stepping up to Quibron-300 capsules.

...for minimal theophylline side effects

Adverse reactions to theophylline are related to serum levels and are usually not a problem at concentrations below 20 mcg/ml. Of 45 patients studied[1] after a single dose, only seven reported adverse reactions. The most common reaction was a feeling of lightheadedness by three of these seven patients.

Reference 1 Data on file. Mead Johnson Pharmaceutical Division.

Indications: For the symptomatic treatment of bronchospastic conditions such as bronchial asthma, asthmatic bronchitis, chronic bronchitis, and pulmonary emphysema.
Dosage: Quibron—Adults: 1-2 capsules or 1-2 tablespoonfuls elixir every 6-8 hours. Children under 12: 4-6 mg theophylline/kg body weight every 6-8 hours.
Quibron-300— Adults: 1 capsule every 6-8 hours.
Theophylline dosage may be cautiously increased to 2000 mg/24 hour in adults and 9 or 10 mg/kg every 6 hours in children. Monitoring of serum theophylline levels at higher dosages is recommended.
Precautions: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other xanthine derivatives concurrently. Use in case of pregnancy only when clearly needed.
Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 μg/ml.
How Supplied: Quibron Elixir: Bottles of 1 pint and 1 gallon. Quibron Capsules: Bottles of 100 and 1000 and unit-dose packs of 100. Quibron-300 Capsules: Bottles of 100.

Mead Johnson PHARMACEUTICAL DIVISION

© 1978 Mead Johnson & Company • Evansville, Indiana 47721 U.S.A.

MJL 7-4280

County Society Officers, Executive Directors, and Meeting Dates

First District

Councilor: *Stewart B. Dunsker, M.D.,* 506 Oak Street, Cincinnati 45219.

ADAMS: William J. Lundy, M.D., President, 522 E. Main St., West Union 45693; David Pixley, M.D., Secretary-Treasurer, 85 S. Main, Peebles 45660. Second Tuesday.

BROWN: Gene F. Conway, M.D., President, 315 E. State St., Georgetown 45121; Charles Hannah, M.D., Secretary-Treasurer, Sardinia Medical Clinic, Sardinia 45171. First or second Sunday.

***BUTLER:** James I. Scott, Jr., M.D., President, 1380 N.W. Washington, Hamilton 45013; John M. Evans, M.D., Secretary-Treasurer, 685 Tari Lane, Hamilton 45013; Mrs. Joan Williams, Executive Secretary, P.O. Box 325, Hamilton 45012, (513) 893-1410. Fourth Wednesday, October-May except December.

CLERMONT: Natvarlal L. Patel, M.D., President, P.O. Box 585, Williamsburg 45176; William Blake Selnick, D.O., Secretary-Treasurer, Second & E. Loveland Ave., Loveland 45140. Third Wednesday.

CLINTON: Richard Buchanan, M.D., President, 115 W. Main St., Wilmington 45177; H. Chung-Tai Hu, M.D., Secretary-Treasurer, 891 W. Locust St., Wilmington 45177. Fourth Tuesday.

***HAMILTON:** Carl G. Thompson, Jr., M.D., President, 938 Hempstead Dr., Cincinnati 45231; Robert P. Hummel, M.D., Secretary, Eden & Bethesda Aves., Cincinnati 45219; William J. Galligan, Executive Secretary, 320 Broadway, Cincinnati 45202, (513) 721-2345. Second Tuesday except August.

HIGHLAND: Barbara Lustgarten, M.D., President, 1440 N. High St., Box 511, Hillsboro 45133; Glenn B. Doan, M.D., Secretary-Treasurer, 528 South St., Greenfield 45123.

WARREN: George Van Harlingen, M.D., President, 4 Oakwood Ave., Lebanon 45036; Raymond Simendinger, M.D., Secretary, 901 N. Broadway, Lebanon 45036. Second Tuesday.

Second District

Councilor: *W. J. Lewis, M.D.,* 2567 Far Hills Ave., Dayton 45419.

CHAMPAIGN: John H. Flora, M.D., President, 848 Scioto St., Urbana 43078; Barry Paxton, M.D., Secretary-Treasurer, 900 Scioto St., Urbana 43078. Second or third Wednesday.

CLARK: Harry M. Berley, M.D., President, 1425 Xenia Ave., Yellow Springs 45387; James Gianakopoulos, M.D., Secretary, 34 W. High St., Second Floor, Tecumseh Bldg., Springfield 45502; Mrs. Dalia Remys, Executive Secretary, 1002 N. Fountain Ave., Springfield 45504, (513) 324-8618. Third Monday, September-May.

DARKE: James O. Armacost, D.O., President, 414 Walnut St., Greenville 45331; Charles W. Platt, M.D., Secretary, 552 South West St., Versailles 45380. Third Tuesday.

GREENE: Priyakant K. Desai, M.D., President, 1142 N. Monroe Dr., Xenia 45385; Fang Chi Huang, M.D., Secretary-Treasurer, 1337 Hanes Rd., Xenia 45385; Mrs. Virginia Jones, Executive Secretary, 1003 Parnell Dr., Xenia 45385, (513) 372-8011, Ext. 287.

MIAMI: Joseph J. Trevino, M.D., President, 113 Castle Dr., Piqua 45356; Richard H. Burk, M.D., Secretary, 550 Summit Ave., Suite 6, Troy 45373. First Tuesday.

MONTGOMERY: Herman I. Abromowitz, M.D., President, 226 Troy St., Dayton 45404; Samuel A. Laneve, M.D., Secretary, 5752 Hither Green, Dayton 45429; Earl E. Shelton, Executive Director, 280 Fidelity Medical Bldg., Dayton 45402, (513) 223-3185. Fourth Thursday except July and August.

PREBLE: John D. Darrow, M.D., President and Secretary-Treasurer, 101 Edgewood Dr., Eaton 45320.

SHELBY: George J. Schroer, M.D., President, 20 S. Main St., Ft. Loramie 45845; Edward A. Link, M.D., Secretary-Treasurer, Third & Michigan St., Sidney 45365. Second Tuesday, quarterly.

Third District

Councilor: *Alford C. Diller, M.D.,* Medical Arts Bldg., 140 Fox Rd., Van Wert 45891.

***ALLEN:** Thomas R. Leech, M.D., President, 1108 National Bank Bldg., Lima 45801; William T. Collins, M.D., Secretary-Treasurer, Lima Memorial Hospital, Lima 45804; Will Wolf, Executive Secretary, Box 1647, Lima 45802, (419) 228-1105. Third Tuesday, September through May.

AUGLAIZE: Joseph Larj, M.D., President, 1020 W. Auglaize St., Wapakoneta 45895; Herbert S. Wolfe, M.D., Secretary-Treasurer, Box 238, New Knoxville 45871. First Thursday, January, March, May, September, and November.

CRAWFORD: V. Allen Auchard, M.D., President, 130 Hill St., Bucyrus 44820; Michael Johnson, M.D., Secretary-Treasurer, 725 N. Sandusky Ave., Bucyrus 44820.

HANCOCK: Brooks A. Mick, M.D., President, 1450 Fostoria Rd., Findlay 45840; Roy Hutchison, M.D., Secretary, 1818 Chapel Dr., Findlay 45840. Third Tuesday.

(continued on next page)

*These counties change officers between May and September.

County Roster *(continued)*

HARDIN: Larry Morris, M.D., President, R.R. 1, Kenton 43326; Jay E. Pfeiffer, M.D., Secretary-Treasurer, 900 E. Franklin, Kenton 43326. Second Tuesday.

LOGAN: Grant K. Varian, M.D., President, 1008 N. Main St., Bellefontaine 43311; Donald Wyse, M.D., Secretary, Rt. 2, Box 120, West Liberty 43357. Five meetings per year, generally January, March, May, September, and November.

***MARION:** Edward Charnock, M.D., President, F. C. Smith Clinic, 1040 Delaware Ave., Marion 43302; Dennis Rowland, M.D., Secretary-Treasurer, F. C. Smith Clinic, 1040 Delaware Ave., Marion 43302. First Tuesday, September through May.

MERCER: Cecil Pennington, M.D., President, 405 S. Oak, Coldwater 45828; Mahmood Mir, M.D., Secretary-Treasurer, 304 Mooring Line Dr., Celina 45822. Third Thursday.

SENECA: Anthony S. Lupica, M.D., President, 40 Clay St., Tiffin 44883; Azael P. Borromeo, M.D., Secretary-Treasurer, 160 E. Perry St., Tiffin 44883. Third Tuesday except July and August.

VAN WERT: Donald Walters, M.D., President, Rt. 5, Box 349, Van Wert 45891; Terrence L. Johnson, M.D., Secretary-Treasurer, Medical Arts Bldg., Fox Rd., Van Wert 45891.

WYANDOT: Nasser J. Zohoury, M.D., President, 132 E. Wyandot, Upper Sandusky 43351; Joseph J. Browne, M.D., Secretary-Treasurer, 777 N. Sandusky Ave., Upper Sandusky 43351. Second Tuesday.

Fourth District

Councilor: *C. Douglass Ford, M.D.,* 2361 W. Bancroft St., Toledo 43607.

DEFIANCE: Homer C. Brown, M.D., President, 1132 E. Second St., Defiance 43512; Subash Mathew, M.D,. Secretary-Treasurer, 1400 E. Second St., Defiance 43512.

FULTON: Benjamin H. Reed, Jr., M.D., President, 101 Adrian St., Delta 43515; E. T. Miquiabas, M.D., Secretary-Treasurer, 744 Fairway Dr., Apt. 25, Wauseon 43567. Quarterly.

HENRY: Thomas F. Moriarty, M.D., President, 651 Strong St., Napoleon 43545; K. E. Dye, D.O., Secretary-Treasurer, East St., Liberty Center 43532. First Tuesday.

LUCAS: Frederic C. Henry, M.D., President, Toledo Hospital, 2142 N. Cove Blvd., Toledo 43606; Thomas G. Klever, M.D., Secretary, 3030 Sylvania Ave., Toledo 43606; Lee F. Wealton, Executive Director, Secor Professional Bldg., 4428 Secor Rd., Toledo 43623, (419) 473-3200. Fourth Tuesday (Council).

OTTAWA: V. William Wagner, M.D., President, 105 Madison St., Port Clinton 43452; Robert S. Reeves, M.D., Secretary-Treasurer, 504 E. Water St., Oak Harbor 43449. Second Thursday.

PAULDING: Kirkwood A. Pritchard, M.D., President, 119 S. Main, Paulding 45879; Edythe C. Pritchard, M.D., Secretary-Treasurer, 119 S. Main, Paulding 45879. Third Monday.

PUTNAM: James B. Overmier, M.D., President, 109 Main St., Leipsic 45856; Earl D. DeWitt, M.D., Secretary-Treasurer, P.O. Box 148, Columbus Grove 45830. First Tuesday.

SANDUSKY: Samuel R. Lowery, M.D., President, 1236 Napoleon St., Fremont 43420; John L. Zimmerman, M.D., Secretary-Treasurer, Memorial Hospital, Fremont 43420; Mrs. Patsy J. Reed, Executive Secretary, Memorial Hospital of Sandusky County, Fremont 43420, (419) 332-7321. Quarterly.

WILLIAMS: Virgil N. Carrico, M.D., President, Bryan Medical Group, Inc., 442 W. High St., Bryan 43506; Richard L. Hess, M.D., Secretary, Bryan Medical Group, Inc., 442 W. High St., Bryan 43506; Ms. Rebecca Cape, Executive Secretary, Bryan Medical Group, Inc., 442 W. High St., Bryan 43506, (419) 636-4517. Third Tuesday, January, March, May, September, and November.

WOOD: Paul R. Overhulse, M.D., President, 960 W. Wooster, Suite 107, Bowling Green 43402; H. Wesley Brown, M.D., Secretary, 640 S. Wintergarden Rd., Bowling Green 43402. Third Thursday.

Fifth District

Councilor: *Theodore J. Castele, M.D.,* 18869 Canyon Rd., Cleveland 44126.

ASHTABULA: Shepard A. Burroughs, M.D., President, 217 Park Pl., Ashtabula 44004; Samuel Kerneklian, M.D., Secretary-Treasurer, 2420 Lake Ave., Ashtabula 44004; Miss Amy Housel, Executive Secretary, P.O. Box 1772, Ashtabula 44004, (216) 998-3111. Second Tuesday.

***CUYAHOGA:** Edward G. Kilroy, M.D., President, 20800 Westgate Ct., Cleveland 44126; Richard J. Nowak, M.D., Secretary-Treasurer, 20620 N. Park Blvd., Cleveland 44118; Robert A. Lang, Ph.D., Executive Director, 10525 Carnegie Ave., Cleveland 44106, (216) 231-3500.

GEAUGA: Paul Zeit, M.D., President, 13241 Ravenna Rd., Chardon 44024; Shigeki Hayashi, M.D., Secretary-Treasurer, P.O. Box 307, Chesterland 44026; Mrs. Martha Withrow, Executive Secretary, Geauga Community Hospital, P.O. Box 249, Chardon 44024, (216) 286-3961.

LAKE: Roy E. Ronke, Jr., M.D., President, 7408 Cadle Ave., Mentor 44060; Armin J. Green, M.D., Secretary, 7408 Cadle Ave., Mentor 44060; Mrs. Marge McLaren, Executive Secretary, 7408 Cadle Ave., Mentor 44060, (216) 255-2233. February, May, September, and November. (Indicate on all mail: Lake County Medical Society.)

Sixth District

Councilor: *C. Edward Pichette, M.D.,* 1019 Boardman-Canfield Rd., Youngstown 44512.

COLUMBIANA: Robert Beatty, M.D., President, 146 W. Fifth St., East Liverpool 43920; Manola Mapa,

(continued on page 251)



Tolinase®
tolazamide, Upjohn

Please contact your Upjohn representative for additional product information.

Upjohn

J-5695-6

©1977 THE UPJOHN COMPANY

Harding Hospital

ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

MEMBER BLUE CROSS OF CENTRAL OHIO

ADMISSION AND PRACTICES CONDUCTED WITHOUT REGARD TO RACE, CREED, OR NATIONAL ORIGIN

Offering a Full Range of Psychiatric Services

- ★ Inpatient Services for 120
- ★ Individual and Group Psychotherapy
- ★ Professional Adjunctive Therapy
- ★ Family Therapy
- ★ Special Care for the Disturbed Patient
- ★ Day Treatment for Adults and Adolescents
- ★ Halfway House
- ★ Family Care
- ★ Outpatient Treatment
- ★ Consultation and Evaluation
- ★ Special Program for Adolescents, Including School

For further information, call (614) 885-5381

George T. Harding, Jr., M.D.
Medical Director

Donald L Hanson
Administrator

445 East Granville Road
Worthington, Ohio 43085

IMMKE CIRCLE LEASING INC

Endorsed Leasing Company
Of The Ohio State Medical Association

Immediate delivery on many 1978 models

We lease all foreign and domestic makes and models including Mercedes, Jaguar, Porsche, etc.

Many people think of leasing as just automobiles.
We do that too, but, in addition, we want to lease you any professional equipment.

Immke Circle Leasing, Inc.
32 South Fifth Street
Columbus, Ohio 43215

Telephone 614-228-1701 or Toll Free 1-800-282-0256

County Roster *(continued)*

M.D., Secretary-Treasurer, 129 W. 4th St., East Liverpool 43920; Mrs. Gilson Koenreich, Executive Secretary, 163 Park Ave., Salem 44460, (216) 337-8859. Third Tuesday.

MAHONING: George H. Dietz, M.D., President, 5600 Market St., Youngstown 44512; Joseph W. Tandatnick, M.D., Secretary, St. Elizabeth Hospital, 1004 Belmont Ave., Youngstown 44505; Howard C. Rempes, Jr., Executive Secretary, 245 Bel-Park Bldg., 1005 Belmont Ave., Youngstown 44504, (216) 747-4956. Third Tuesday, January, March, May, September, November, and December.

STARK: Reich L. Watterson, M.D., President, 2833 Cleveland Ave., N.W., Canton 44709; David Montgomery, M.D., Secretary-Treasurer, 515 Third St., N.W., Canton 44703; Raymond T. Sullivan, Jr., Executive Secretary, 4150 Belden Village St., N.W., Canton 44718, (216) 492-3333. Second Thursday.

TRUMBULL: George Mokris, M.D., President, 689 N. Park Ave., Warren 44483; John Biggins, M.D., Secretary-Treasurer, 8887 Echo Lake Dr., N.E., Warren 44484; Mrs. Delores B. Bevan, Executive Secretary, 280 N. Park Ave., Warren 44481, (216) 394-4556. Third Wednesday.

Seventh District

Councilor: *Robert E. Rinderknecht, M.D.,* 404 N. Walnut St., Dover 44622.

BELMONT: Lois R. Zimmerman, M.D., President, 110 Walnut St., St. Clairsville 43950; Nermin D. Lavapies, M.D., Secretary-Treasurer, 1220 Hughes Ave., Martins Ferry 43935. Third Thursday, February, March, April, June, September, October, November, and December.

CARROLL: Samuel Weir, M.D., President, 625 N. Market St., Minerva 44657; Nan Bissell, M.D., Secretary-Treasurer, 450 S. Lisbon St., Carrollton 44615. Third Tuesday.

COSHOCTON: Sang M. Suh, M.D., President, 1419 Orange St., Coshocton 43812; Myron Saturski, M.D., Secretary-Treasurer, 149 S. Bridge St., Newcomerstown 43832. Second Tuesday.

HARRISON: James Scott, M.D., President, Box 512, Main St., Scio 43988; Isam Tabbah, M.D., Secretary-Treasurer, R.D. 1, Cadiz 43907. Second Tuesday.

JEFFERSON: Nick Terezis, M.D., President, 141 Brady Circle W., Steubenville 43952; Frank J. Petrola, M.D., Secretary-Treasurer, 2204 Sunset Blvd., Steubenville 43952. First Tuesday.

MONROE: Donald R. Piatt, M.D., President, 154 S. Main St., Woodsfield 43793; Jack M. Matheny II, M.D., Secretary-Treasurer, Monroe County Clinic, Fairport Rd., R.D. 3, Woodsfield 43793. First Wednesday of every fourth month.

TUSCARAWAS: Robert C. Hastedt, M.D., President, Union Hospital, Dover 44622; Jose Martinez, M.D., Secretary, 108 N. Second St., Dennison 44631. Second Wednesday.

(continued on next page)

This year . . . the chances of your being seriously disabled are far greater than death.

THIS CHART SHOWS JUST HOW MUCH GREATER.

CHANCES OF DISABILITY VS. DEATH

If you are age:	A disability of 90 days or longer is this much more likely to occur than death this year
22	7½ TIMES GREATER
32	6½ TIMES GREATER
42	5½ TIMES GREATER
42	4 TIMES GREATER
47	3½ TIMES GREATER
52	2½ TIMES GREATER
62	2 TIMES GREATER

Source: The National Underwriter Company 420 E. 4th St. Cincinnati, Ohio 45202

When disability occurs, will your protection be adequate?

To be sure you have an income when you're disabled, enroll in . . .
THE DISABILITY INCOME PROTECTION PLAN which your Ohio State Medical Association co-sponsors with many local medical societies. You may apply for benefits up to $500 weekly.

CONTACT:

TURNER AND SHEPARD INC.

Columbus, Ohio 43215	17 South High Street	Phone (614) 228-6115
Akron, Ohio 44313	3090 West Market Street	Phone (216) 434-5000
Cincinnati, Ohio 45241	4015 Executive Park Drive	Phone (513) 563-4220
Cleveland, Ohio 44134	1440 Snow Road	Phone (216) 741-4466
Toledo, Ohio 43606	3450 West Central Avenue	Phone (419) 535-0616

County Roster *(continued)*

Eighth District

Councilor: *Richard E. Hartle, M.D.,* 600 Pleasantville Rd., Lancaster 43130.

ATHENS: Atmaram S. Gawande, M.D., President, 400 E. State St., Athens 45701; Lester A. Hamilton, M.D., Secretary-Treasurer, 400 E. State St., Athens 45701. Second Tuesday, March, June, September, and December.

FAIRFIELD: Lewis H. Urling, M.D., President, 214 Harmon Ave., Lancaster 43130; John G. O'Handley, M.D., Secretary-Treasurer, Baldwin Run Medical Bldg., 600 Pleasantville Rd., Lancaster 43130. Second Tuesday.

GUERNSEY: Raj Tripathi, M.D., President, Medical Arts Bldg., Cambridge 43725; Nila Z. Sayat, M.D., Secretary-Treasurer, 64979 Old Rt. 21, R.D. 3, Cambridge 43725. First Tuesday except July and August.

LICKING: John J. Winsch, M.D., President, 399 E. Main St., Newark 43055; Claude R. Rousseau, M.D., Secretary-Treasurer, 155 McMillen Dr., Newark 43055; Mrs. Dorothy Watson, Executive Secretary, 1320 W. Main St., Newark 43055, (614) 344-0331, Ext. 394. Fourth Tuesday except June, July, August, and December.

MORGAN: Asa H. Whitacre, M.D., President, Chesterhill 43728; Henry Bachman, M.D., Secretary-Treasurer, 426 E. Union Ave., McConnelsville 43756.

MUSKINGUM: Holton C. Letson, M.D., President, 2315 Maple Ave., Zanesville 43701; Thomas N. Ruggles, M.D., Secretary-Treasurer, 515 Taylor, Zanesville 43701. First Tuesday.

NOBLE: Frederick M. Cox, M.D., President, P.O. Box 330, Caldwell 43724; Edward G. Ditch, M.D., Secretary-Treasurer, P.O. Box 239, Caldwell 43724. First Tuesday.

PERRY: Alfredo Cruz, M.D., President, 203 N. Main St., New Lexington 43764; Charles McDougal, M.D., Secretary-Treasurer, Dallas Ave., New Lexington 43764.

WASHINGTON: Richard R. Hille, M.D., President, 323 2nd St., Marietta 45750; Bae Suk Lee, M.D., Secretary-Treasurer, Marietta Memorial Hospital, Surgery, Marietta 45750. Second Wednesday, October through May.

Ninth District

Councilor: *Thomas W. Morgan, M.D.,* Holzer Medical Center Clinic, P.O. Box 344, Gallipolis 45631.

GALLIA: Donald M. Thaler, M.D., President, Holzer Clinic Ltd., P.O. Box 344, Gallipolis 45631; Restituto H. Alonzo, M.D., Secretary-Treasurer, Holzer Clinic Ltd. P.O. Box 344, Gallipolis 45631. Second Tuesday.

HOCKING: Alfonso Gay, M.D., President, 664 N. Rt. 5, Logan 43138; George Ralph, M.D., Secretary-Treasurer, 664 N. Rt. 5, Logan 43138.

JACKSON: John Zimmerly, M.D., President, 35 Vaughn St., Jackson 45640; Carl J. Greever, M.D., Secretary-Treasurer, 35 Vaughn St., Jackson 45640.

LAWRENCE: Pacifico Dorado, M.D., President, P.O. Box 603, Ironton 45638; David A. Pack, M.D., Secretary, 2412 S. 6th St., Ironton 45638. Second Thursday quarterly.

MEIGS: Selim J. Blazewicz, M.D., President, P.O. Box 511, Pomeroy 45769; Joseph J. Davis, M.D., Secretary-Treasurer, 939 Ash St., Middleport 45760. When called.

PIKE: Kenneth A. Wilkinson, M.D., President, Rt. 2, Hilltop Medical Center, Waverly 45690; J. Wallace Cleland, M.D., Secretary-Treasurer, 327 Wendy Lane, Bristol Village, Waverly 45690. First Tuesday.

SCIOTO: Otto F. Apel, Jr., M.D., President, 1725 27th St., Suite 2-D, Portsmouth 45662; Laura C. Pagel, M.D., Secretary-Treasurer, Mercy Medical Plaza, Portsmouth 45662; Lowell Thompson, Executive Secretary, P.O. Box 1348, Portsmouth 45662, (614) 354-7581. Second Tuesday.

VINTON: No active society.

Tenth District

Councilor: *J. Hutchison Williams, M.D.,* 4355 Sharon Ave., Columbus 43214.

DELAWARE: James R. Parker, M.D., President, 90 E. William St., Delaware 43015; Lloyd E. Moore, M.D., Secretary-Treasurer, 6 S. Main St., Magnetic Springs 43036. Third Tuesday, March, May, September, and December.

FAYETTE: Robert D. Woodmansee, M.D., President, 403 E. Market St., Washington C.H. 43160; Marvin H. Roszmann, M.D., Secretary-Treasurer, P.O. Box 547, Washington C.H. 43160. Second Friday.

FRANKLIN: James E. Matson, M.D., President, 6562 Plesenton Dr., Worthington 43085; J. Richard Briggs, M.D., Secretary-Treasurer, 423 E. Town St., Columbus 43215; James S. Imboden, Executive Director, 600 S. High St., Columbus 43215, (614) 224-6116. April, August, September, October, and December.

***KNOX:** Alan Fairchild, M.D., President, 5 N. Gay St., Mt. Vernon 43050; James H. Risko, M.D., Secretary-Treasurer, 307 Vernedale Dr., Mt. Vernon 43050. First Wednesday.

MADISON: Brawley Arikawa, M.D., President, 214 Elm St., London 43140; Sol Maggied, M.D., Secretary-Treasurer, 15 E. Pearl St., West Jefferson 43162. Four meetings a year.

MORROW: John Sweeney, M.D., President, 900 Meadow Dr., Mt. Gilead 43338; William E. DeVol, M.D., W. Walnut St., Marengo 43334. First Tuesday.

PICKAWAY: Frank R. Moore, M.D., President, 470 N. Court St., Circleville 43113; Michael Geron, M.D., Secretary-Treasurer, 610 Northridge Rd., Circleville 43113. Second Tuesday except July and August.

ROSS: David H. Ater, M.D., President, 612 Central Center, Chillicothe 45601; Lowell Smith, M.D., Secretary-Treasurer, 612 Central Center, Chillicothe 45601. First Thursday.

UNION: John B. Zeigler, M.D., President, 18522 Raymond Rd., Marysville 43040; May B. Zaugg, M.D., Secretary-Treasurer, 509 Hickory Dr., Marysville 43040. First Tuesday, February, April, October, and December.

Eleventh District

Councilor: *S. Baird Pfahl, Jr., M.D.,* 521 W. Perkins Ave., Sandusky 44870.

ASHLAND: Charles A. Slagle, D.O., President, 350 Hillcrest Ave., Ashland 44805; Varalakshmi Dheenan, M.D., Secretary-Treasurer, 203 Maple St., Ashland 44805. First Tuesday.

ERIE: Robert J. Ailes, M.D., President, 3103 S. Campbell St., Sandusky 44870; John P. Cook, M.D., Secretary, 3004 Hayes Ave., Sandusky 44870; Mrs. David Wolfert, Executive Secretary, Scheid Rd., Box 381-E, Huron 44839, (419) 433-3097. Second Tuesday except July and August.

HOLMES: Charles Hart, M.D., President, 109 S. Clay St., Millersburg 44637; William V. Dugan, M.D., Secretary-Treasurer, Pomerene Hospital, Millersburg 44637. Third Monday.

HURON: John E. Rosso, M.D., President, 218 Myrtle Ave., Willard 44890; Shan A. Mohammed, M.D., Secretary-Treasurer, 3 Milan Manor Dr., Milan 44846. Second Wednesday, February, April, June, October, and December.

LORAIN: Gabriel Sabga, M.D., President, 1511 Lincoln Blvd., Lorain 44055; Kenneth O'Connor, M.D., Secretary-Treasurer, 319 Michigan Ave., Elyria 44035; Mrs. Carol Boyson, Executive Secretary, 1480 N. Ridge Rd., E., Elyria 44035, (216) 324-3093 or 233-6561. Second Tuesday, September through April.

MEDINA: William D. Robertson, M.D., President, 251 S. Court St., Medina 44256; Michael Bianco, M.D., Secretary-Treasurer, 251 Leatherman Rd., Wadsworth 44281; John E. Gerding, Executive Secretary, 3377 Forest Hills Dr., Medina 44256, (216) 725-5331. Third Thursday except December and summer.

RICHLAND: Eugene Sherman, M.D., President, 295 Glessner Ave., Mansfield 44903; John A. Savoy, M.D., Secretary-Treasurer, 222 Marion Ave., Mansfield 44903; Mrs. M. K. Leggett, Executive Secretary, Mansfield General Hospital, Mansfield 44903, (419) 522-3411. Third Thursday, September through May.

WAYNE: Herbert E. Allshouse, M.D., President, 1740 Cleveland Rd., Wooster 44691; Walter H. Kearney, M.D., Secretary-Treasurer, 1740 Cleveland Rd., Wooster 44691. Second Wednesday.

Twelfth District

Councilor: *William Dorner, Jr., M.D.,* 750 W. Market St., Akron 44303.

PORTAGE: Richard W. Sears, M.D., President, 155 N. Water St., Kent 44240; Alif A. Kuri, M.D., Secretary-Treasurer, 6693 N. Chestnut St., Medical Arts Bldg., Ravenna 44266. Second Tuesday.

SUMMIT: Manley L. Ford, M.D., President, 719 Centran Bldg., Akron 44308; Charles V. Bowen, M.D., Secretary, 925 Centran Bldg., Akron 44308; S. H. Mountcastle, Managing Director, 430 Grant St., Akron 44311, (216) 434-1921. First Tuesday, January, March, May, July, September, and November.

Practice Productivity® Inc.

Practice Productivity Inc. is o nationol medicol monogement consulting firm which offers educational ond motivationol workshops in sound business concepts to procticing physicions, residents, office monagers, ond medical ossistonts. Proctice Productivity (PPI) olso provides notionwide consulting services to physicions ot their privote proctice.

The professionol stoff of Proctice Productivity consists of seosoned consultonts with different backgrounds ond mony years of experience in solving the reol problems of the procticing physicion in either solo or group proctice. Some bockground credentiols of the stoff ore: psychologist, lowyer, accountont, phormocist, medicol office monoger, educator, systems onalyst, EDP (computer expertise), business odministration. Such o multi-foceted staff enables PPI to relote to the multi-foceted circumstonces found in most privote medicol proctices.

For further information about consulting services or practicing physician, resident, office manager, or medical assistant workshops contact:

Duane M. Johnson, Ph.D.
Executive Vice President
Practice Productivity Inc.
2000 Clearview Avenue
Atlanta, Georgia 30340
(404) 455-7344

THE OHIO STATE Medical Association Cancer Education Series*

Malignant Melanoma

Charles D. Cobau, M.D.
Ranieri Rocchi, M.D.

ALTHOUGH NOT A common neoplasm, the incidence of malignant melanoma (MM) has increased, particularly in lightly pigmented individuals residing in warmer climates. Malignant melanoma is characterized in the majority of patients by the development of irregular margins or pigmentation of a preexisting nevus. Melanomas occur in three recognizable forms.[1] Approximately two-thirds of them are of the superficial-spreading type most frequently arising on the back and exposed surfaces of the head and neck in men and on the extremities in women. They appear as a small, pigmented lesion with irregular coloration and borders, often with a surrounding halo. The lentigo-maligna type occurs on the head, neck, and back of the hands developing in a freckle-like lesion which may have been present for several decades. Nodular MM usually is observed on the back, head, and neck of men as a reddish-blue or blue-black papule.

Diagnosis and Staging

All lesions possessing any of the characteristics described above should be biopsied. The biopsy specimen should include the entire lesion and full-skin thickness with margins of 2 mm to 3 mm. If the diagnosis of MM is confirmed histologically, the depth of penetration should be determined. The American Joint Committee for Cancer Staging and End Results accepts the Clark classification which describes five levels of invasion.[2] Levels I and II, where the tumor is confined to the epidermis, typically observed in superficial spreading MM, are associated with a good prognosis. Level III, with invasion of the papillary-reticular dermis, is associated with metastatic disease in approximately 50% of MM patients. Invasion of the reticular dermis (Level IV) and subcutaneous tissue (Level V) is associated with distant metastatic disease in the majority of patients. Prior to definitive treatment, all patients with MM should be evaluated for distant metastases including history, physical examination, radiographic examination of the lungs, and liver, bone and brain scans.

Primary Treatment

If there is no evidence of metastases, wide re-excision of the biopsy site is indicated. It should include skin margins of 3 cm to 5 cm and subcutaneous fat to the deep fascial layers.[3] A split-thickness graft usually is required for closure. Incontinuity resection of the regional lymph nodes should be performed when technically feasible. Discontinuous regional-node resection is not indicated unless the regional lymph nodes are palpable and clinically suspicious for metastatic disease. Regional limb perfusion with cytotoxic drugs is not a substitute for adequate excision, but it can be effective in locally far-advanced or recurrent disease as an alternative to amputation.[4]

Disseminated Disease

Unfortunately, despite prompt, appropriate treatment of the primary site and regional lymph nodes, a significant proportion of patients develop disseminated disease. The most effective chemotherapeutic agent is dimethyltriazeno imidazole carboxamide (DTIC). The

Dr. Cobau, Toledo, Attending Staff, Flower and Toledo Hospitals; and Associate Clinical Professor of Medicine, Medical College of Ohio at Toledo.
Dr. Rocchi, Toledo, Staff Member, Flower, Saint Lukes, and Toledo Hospitals.
Submitted September 27, 1977.

The Journal is pleased to publish this series through the cooperation of the OSMA Committee on Cancer and the American Cancer Society, Ohio Division Inc.

response rate is approximately 20%.[5] Regressions generally are of short duration, and complete responses are infrequent. The combination of DTIC with other cytotoxic drugs has not yielded significantly increased response rates. Regression of disseminated disease has not been observed with nonspecific immune stimulants such as BCG vaccination. Intralesional injection of BCG causes regression of cutaneous lesions and occasionally noninjected, remote cutaneous lesions.

A major effort has been made to determine if systemic chemoimmunotherapy can prevent metastatic disease following surgical resection. A prospective study comparing DTIC in treated patients with untreated controls failed to detect any difference in disease-free interval or survival.[6] Current studies use combinations of DTIC and other cytotoxic drugs with and without immune therapy but at the present time, routine, postoperative administration of systemic chemotherapeutic agents and/or immune therapy cannot be advocated.

Prognosis

The prognosis for MM is related to the depth of penetration of the primary tumor into the skin and subcutaneous tissues. Unfortunately, at the present time, there appears to be no effective treatment for prevention of the subsequent development of disseminated disease in high-risk patients. Treatment of disseminated disease results in relatively infrequent and short-lived disease regression. Because of the immunogenicity of MM, further investigation with specific immune therapy may ultimately provide more effective control of this malignancy.

References

1. Clark WH Jr, Mihm MC Jr: Moles and malignant melanoma, in *Dermatology in General Medicine,* New York, McGraw Hill, 1971, pp 491-511.

2. Davis NC, Herron J, McLeod GR: The macroscopic appearance of malignant melanoma of the skin. *Med J Aust* **2**:883-886, 1966.

3. Handley WS: The pathology of melanotic growths in relation to their operative treatment. *Lancet* **1**:996-1003, 1907.

4. Creech O, Krementz ET: Regional perfusion in melanoma of limbs. *JAMA* **188**:855-858, 1964.

5. Luce JK: Chemotherapy of malignant melanoma. *Cancer* **30**:1604-1615, 1972.

6. Hill GJ II, Metter GE, Moss S, et al: DTIC therapy for melanoma: correlation of toxicity with response and longevity in 742 patients. *Proc Am Soc Clin Oncol* **17**: 244, 1976.



Auxiliary Involvement in Immunization Campaign

Ingrid May, President, OSMA Auxiliary

Immunizations have been among the most effective and most acclaimed successes of modern medicine. The introduction of the polio vaccines during the 1950s was a major breakthrough. So successful were the vaccines that many patients and physicians began thinking of once-dreaded diseases like diphtheria and rubella as problems of the past. That apparently led to overconfidence, for recent years have seen reports of significant numbers of American children unprotected against one or more of the communicable diseases.

Responding to these reports, the Immunization Action Month (IAM), a national awareness campaign designed to urge parents and physicians to check the immunization status of all children, was promoted. The IAM program did begin to reverse the declining trend in immunizational levels and resulted in the immunization of millions of children. But many others are still not fully immunized. The Secretary of HEW, Joseph Califano, announced that 19 million are unprotected against polio, 12 million against measles, 12.5 million against rubella, and 15.5 million against diphtheria, tetanus, and pertussis. Such statistics indicated the need for a new, national immunization campaign designed to increase public awareness about low immunization levels. The goal of the new program is to raise these levels from the present 65% to more than 90% within the next 30 months.

How Does Ohio Compare to the National Picture?

John Ackerman, M.D., Director, Ohio Department of Health, estimates that 200,000 Ohio school children are not fully protected against polio, while 100,000 do not have measles protection. Ohio can expect more measles epidemics until "catch-up" immunization campaigns are successful.

During the 1977 AMA Annual Convention, Richard E. Palmer, M.D., then AMA president, announced the new AMA immunization campaign. He stressed that the success of the campaign hinged on the cooperation and efforts of Auxiliary members across the country. We have enthusiastically endorsed the campaign.

The health education campaign consists of TV public-service announcements, a special hand-puppet film for children's shows, and a radio-tape series to make children aware of the need to be immunized. Through the children, we hope to reach the parents!

The theme of the campaign is children playing on a specially labeled hopscotch court. Each box in the court is labeled with a controllable disease and "Sky Blue" is replaced by "Immunization." To take the theme out of the TV set and into the daily lives of children, Auxilians are painting hopscotch courts on school playgrounds. A short puppet-show film, intended for children's programs, is also promoted by the Auxiliary. The show has been filmed at the fictional "AMA Immunization Bowl" and features some mock-sinister puppets, each representing a specific disease. A sports announcer reports on a hopscotch game between the diseases and the forces of "good" (immunization). Of course, the diseases are vanquished.

Ohio Auxiliary Activities

Auxiliary members in Ohio have been busy since September of 1977 making communities aware of the immunization program. All 52 county auxiliaries received stencils to paint the hopscotch courts on playgrounds. Franklin Walters, Superintendent of Public Instruction, Ohio Department of Education, was informed by the OSMA Auxiliary of the project and asked to communicate this information to superintendents of schools in each Ohio school district. The Auxiliary received tremendous cooperation. So far, eight county auxiliaries have painted a total of 142 hopscotch courts on school play grounds. Weather permitting, many other county auxiliaries are planning this project for the spring. Countywide educational programs involving auxiliary members, physicians, local public health officers, youth, and teachers are also in progress. Press releases were given to newspapers, television, and radio stations. Auxiliary members from Cuyahoga, Marion, and Montgomery counties appeared on TV-talk shows or radio to promote adequate immunization schedules.

Ohio Department of Health

Thomas Halpin, M.D., called on the Auxiliary to play a very important role in Ohio's new "immunization initiative." Ohio is aiming to protect at least 90% of our children under the age of 15 against diphtheria, pertussis, tetanus, polio, measles, rubella; mumps is added to the list for preschool children. To obtain this goal, various methods of education and services have been designed. Auxiliary assistance is sought in the issuing of a specifically prepared brochure to mothers of all newborn infants during the maternity stay in the hospital. The brochure presents immunization recommendations for the 155,000 births that occur annually. It also describes the danger of preventable diseases and how the diseases can be prevented. An immunization record accompanies each brochure which is free of charge to all local hospitals. Auxiliary members stand ready to help the hospitals and the local health departments get this program off the ground.

As Auxiliary members, we want to support efforts to assure that infants are adequately immunized within the recommended time frames and that older, incompletely-immunized children receive their "catch-up" vaccines.

THE OHIO STATE Medical Association New Members

ALLEN (Lima)
Youn Seok Seo

ASHLAND (Ashland)
Evelyn Alcantara
Syed J. Ali
Young C. Shinn

ATHENS (Athens)
Larry S. Dansky
Mark T. Rothstein

CLARK (Springfield)
Keith Linas
Arnold Reeve

CUYAHOGA (Cleveland unless noted)
Hong Goo Ahn
Jack T. Andrish
Leonard S. Berman
Javier L. Clemente
Corazon M. DeGuzman
Ruth A. Embury
Gerald A. Hoeltge
Hagop Ishkhanian
Kailash R. Kedia
John J. Kelly, Jr., Twinsburg
Thomas H. Kim
Gregory F. Kondray
Ernest A. Lewandowski
William S. Makarowski
Sheldon I. Miller
Sami Fauad I. Nicola
Saroj A. Pagedar
Joan C. Palomaki
Ronald R. Reimer
Robert P. Riggs
Frank E. Seidelmann
Leslie R. Sheeler
Marvin D. Shi III
Mahesh N. Shroff
Eulogio R. Sioson
William O. Wagner
Lutgarda S. Tolentino

DEFIANCE (Defiance)
John C. Zeldenrust

FRANKLIN (Columbus)
Terry L. Irwin

FULTON (Wauseon unless noted)
Jayantilal D. Galani
Estela T. Miquiabas
David Thompson, Archbold

GALLIA (Gallipolis)
Ijaz Ahmad

GREENE (Fairborn)
Manoj R. Desai

HAMILTON (Cincinnati)
Ali G. Arani
John O. Bishop
V. Franklin Colon
Judith S. Daniels
William D. Falvey
Robert S. Heidt, Jr.
Kris Johansson
William R. Krall
Dong Won Lim
Michael S. Rappoport
Vijay Sanghvi
Louis E. Schroder
David Tondow, Jr.
Diane M. Vickery
Gloria Walker
John Dirk Wassner
Francis D. Winter

HARRISON (Cadiz)
Isam Tabbah

HURON
Roy Harvey, Bellevue
Vernon Vore, Willard

LAKE
Edgardo R. Aro, Cleveland
Gilbert Erlechman, Mentor
Martin L. Mandel, Willoughby

MADISON (London)
Mohammed A. Jan

MAHONING
Tejinder Singh Bal, Youngstown
Suman Kumar Mishr, Poland
Usha Sethi, Youngstown

MARION (Marion)
Leonard J. Janchar, Jr.
Leroy J. Nelson
Marwan Yanes

MEDINA (Medina)
Michael J. Basile

MERCER (Celina)
Paul Schreibman

MUSKINGUM (Zanesville)
Gordon A. Bailey

PIKE (Waverly)
Rodegelio C. Estrada

PORTAGE (Kent)
Charles Clement Voorhis

RICHLAND (Mansfield unless noted)
Feredoun Behi
Thomas Blackstone
Wojceich Brym
Farid Nashed, Shelby
Daniel F. Reynolds

ROSS (Chillicothe)
Kamala Saxena

SANDUSKY (Fremont)
Thomas J. Hadley

TUSCARAWAS (Dover)
Pratima Y. Shah

WASHINGTON (Marietta)
Francis J. Natolis

WAYNE
Larry D. Sander, Orrville
Owen Logee, Wooster

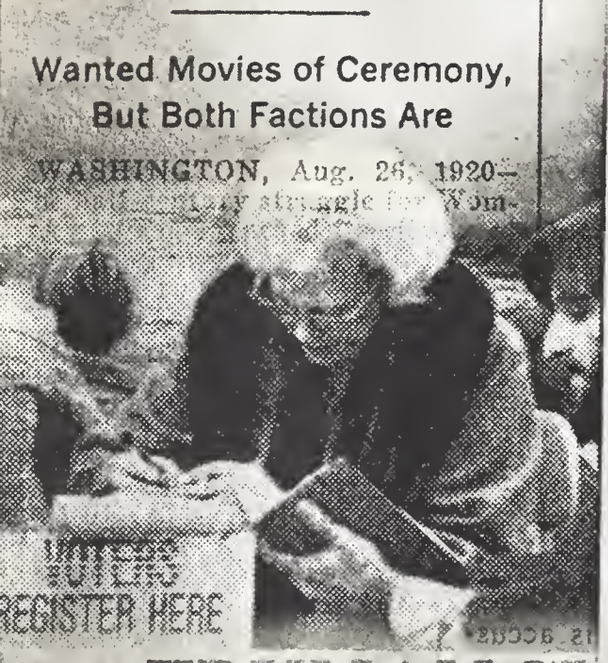
COLBY PROCLAIMS WOMAN SUFFRAGE

Signs Certificate of Ratification at His Home Without Women Witnesses.

MILITANTS VEXED AT PRIVACY.

Wanted Movies of Ceremony, But Both Factions Are

WASHINGTON, Aug. 26, 1920—



Social Security Bill Is Signed; Gives Pensions to Aged, Jobl

Roosevelt Approves Message Intended to Benefit 30,00 Persons When States Adopt Cooperating Laws–He C the Measure 'Cornerstone' of His Economic Progra

WASHINGTON, Aug. 14, The Social Security Bill, pro a broad program of unemplo insurance and old age pe and counted upon to benefi 20,000,000 persons, became l day when it was signed by dent Roosevelt in the prese those chiefly responsible fo ting it through Congress.

Mr. Roosevelt call[illegible] the m "the cor[illegible]erstone [illegible] a str which is [illegible]eing [illegible] [illegible] is me[illegible]s comple[illegible] ri[illegible]o

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today, 94 to 0, and sen[illegible]

TRUMAN CLOSES TED NATIONS CONFEREN ITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

JUL SIGNE the Draf Ends No

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after re-



PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA
THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION
1155 FIFTEENTH ST, N W, WASHINGTON, D C 20005

THE OHIO STATE Medical Association News

New Patient Brochure To Accompany Birth Control Pills

The Food and Drug Administration (FDA) has established new patient-information requirements for birth control pills, including a warning that women who take the pill should not smoke. Effective April 3, 1978, women will receive a brochure explaining the benefits and risks associated with this form of contraception each time a prescription for the pill is filled. Information in the brochure will be summarized in a separate, easy-to-read leaflet. Both the brochure and the leaflet must be provided by the drug dispenser.

A boxed warning advising women who take the pill not to smoke will appear in both the brochure and the leaflet. It reads:

Cigarette smoking increases the risk of serious adverse effects on the heart and blood vessels from oral contraceptive use. This risk increases with age and with heavy smoking (15 or more cigarettes per day) and is quite marked in women over 35 years of age. Women who use oral contraceptives should not smoke.

Arizona MD Must Carry Insurance

The Arizona Supreme Court has ruled that a physician must take out professional liability insurance if he wants to retain his hospital staff privileges. The hospital has the right "to take reasonable measures to protect itself and the patients it serves," the tribunal said. The Court's action overruled an earlier decision by an intermediate appellate court that held in the physician's favor. The lower court observed that the physician's failure to carry insurance would not compel the hospital, a private, nonprofit institution, to assume his risks, since he is "an independent contractor" able to meet any claim with his own financial resources. The issue came to court when the hospital suspended the physician's privileges after he had notified the institution he would not renew his malpractice policy.

HEW Grant to Ohio Organization

The Ohio Association for Alcoholism Programs, Inc., Columbus, received a $50,000 grant from the Department of Health, Education, and Welfare. This grant to the Ohio Volunteer Utilization Project in Alcoholism was one of 19 to help state-level volunteer organizations promote growth and development of volunteer activities in the alcoholism field.

TREAT THE SYMPTOMS IN THE GERIATRIC PATIENT

APATHY • IRRITABILITY
FORGETFULNESS • CONFUSION



Cerebro-Nicin® CAPSULES

A GENTLE CEREBRAL STIMULANT & VASODILATOR FOR GERIATRIC PATIENTS

Each CEREBRO-NICIN capsule contains:
Pentylenetetrazole .....100 mg. • Nicotinic Acid ...100 mg.
Ascorbic Acid .....100 mg. • Thiamine HCl .....25 mg.
l-Glutamic Acid .....50 mg. • Niacinamide .....5 mg.
Riboflavin .....2 mg. • Pyridoxine HCl .....3 mg.
AVAILABLE: Bottles 100, 500, 1000
SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and abdominal cramps. The reaction is usually transient.
INDICATIONS: As a cerebral stimulant and vasodilator.
RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.
WARNING: Overdosage may cause muscle tremor and convulsions.
CONTRAINDICATIONS: Epilepsy or low convulsive threshold.
CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

Write for literature and samples . . .
BROWN THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057

Public Has Greatest Confidence In Medical Profession

According to a Harris Survey taken in late 1977, the public shows its greatest confidence in the "people running medicine." Fifty-five percent of the public said it has "a great deal of confidence" in medical leadership, compared to 42% in a 1976 survey. Scoring second to medical leadership was higher education, with 41%. An earlier Harris Survey, designed to test whether the public thinks the leaders of various institutions and professions are "in touch with" the people they are supposed to lead or help, showed that 73% felt medicine's leaders "really know what people want." Sixty-nine percent thought so in 1975.

Another survey, conducted by the University of Chicago Center for Health Administration this January, revealed that 88% of the American people are "satisfied" with their health care and that no one population group has great trouble getting to see a doctor. In another Harris Survey, 62% of the public said the current health care system is acceptable, but only 39% showed real enthusiasm for it. However, 49% of those polled were opposed to "a national health service under which everyone could get care paid for out of taxes. . . ." Only 31% favored such a plan.

Medical Board Activity

The following is a list of activities and actions undertaken from February 1, 1978 to February 28, 1978 by the Ohio State Medical Board

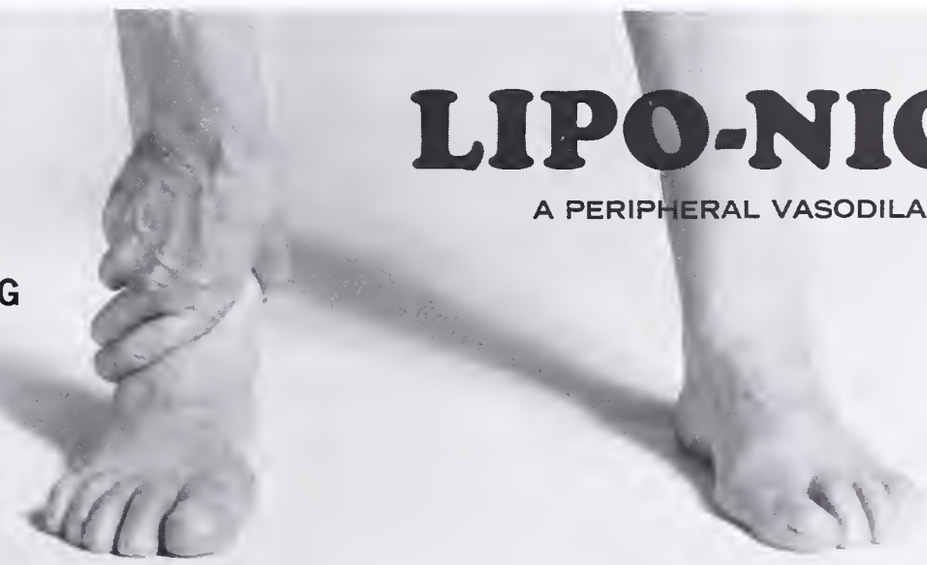
LICENSURE ACTIVITY

American and Canadian Graduates		
Licensed by Endorsement	M.D.	28
	D.O.	2
Licensed by Examination	M.D.	31
	D.O.	1
Foreign Medical School Graduates		
Licensed by Endorsement		23
Licensed by Examination		44
Sept. 1972 FLEX Board Policy Licenses		4
Endorsements to Other States	M.D.	40
	D.O.	4

ENFORCEMENT ACTIVITY

Formal Citations Issued	1
Board Office Visits with Individuals in Alleged Violation of the Medical Practice Act	3
Voluntary Surrenders of Medical Certificates	0
Arrests for Alleged Illegal Practice of Medicine	0
Formal Hearings on Alleged Violations of the Medical Practice Act	1

COLD FEET
LEG CRAMPS
TINNITUS
DISCOMFORT ON STANDING



LIPO-NICIN
A PERIPHERAL VASODILATOR

IMMEDIATE or GRADUAL
nicotinic acid therapy

IMMEDIATE RELEASE

LIPO-NICIN/100 mg.
Each blue tablet contains:
Nicotinic Acid .....100 mg.
Niacinamide ..... 75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .. 25 mg.
Riboflavin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6).. 10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500, 1000.

LIPO-NICIN/250 mg.
Each yellow tablet contains:
Nicotinic Acid .....250 mg.
Niacinamide ..... 75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .. 25 mg.
Riboflavin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6).. 10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500, 1000.

GRADUAL RELEASE

LIPO-NICIN/300 mg.
Each time-release capsule contains:
Nicotinic Acid ..... 300 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (H-1) .. 25 mg.
Riboflavin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6).. 10 mg.
In a special base of prolonged therapeutic effect.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient. Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur. Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

BROWN THE BROWN PHARMACEUTICAL CO., INC. 2500 West Sixth Street, Los Angeles, California 90057
Write for Literature and Samples
REFER TO PDR

Colleagues in the News

MICHAEL ALTMAN, M.D., Columbus, has been named President of the Ohio Thoracic Society. Dr. Altman is Associate Professor of Medicine at The Ohio State University College of Medicine and Medical Director of the Pulmonary Function Laboratory at University Hospitals.

MICHAEL A. ANTHONY, M.D., Columbus, has assumed the duties of President of the Mount Carmel Medical Staff. A member of the Department of Medicine since 1956, Dr. Anthony was Director of the Medical Education Department from 1961 to 1976. Other officers include **RICHARD F. SLAGER, M.D.,** President-Elect, and **ALFRED F. SHOMAN, M.D.,** Secretary-Treasurer. **ROBERT J. MOUNTS, M.D.,** is Immediate Past-President.

PHILIP L. BAILIN, M.D., Shaker Heights, has been appointed head of the Department of Dermatology at the Cleveland Clinic. A specialist in the chemosurgical removal of skin tumors, Dr. Bailin joined the Clinic's staff in 1975.

The following members of the American College of Radiology will receive certificates of fellowship at the 55th annual meeting of the College in April: **OWEN L. BROWN, M.D.,** Cincinnati; **RICHARD L. KING, M.D.,** Cleveland; **HAROLD B. SPITZ, M.D.,** Cincinnati; **ROBERT P. ULRICH, M.D.**; and **JOHN R. YODER, M.D.,** Toledo.

EARL J. FLEEGLER, M.D., Cleveland, has been promoted to Assistant Clinical Professor of Plastic Surgery at Case Western Reserve University School of Medicine. Dr. Fleegler also is a member of the medical staff of Huron Road Hospital.

WILLIAM GERHARDT, M.D., is the new president of the medical and dental staff of Children's Hospital Medical Center, Cincinnati. Dr. Gerhardt is in private practice in Westwood and Associate Clinical Professor of Pediatrics at the University of Cincinnati. Other officers are **K. KURT BOFINGER, M.D.,** vice-president; and **MARK McGOVERN, M.D.,** secretary/treasurer.

JOSEPH GHORY, M.D., Cincinnati, was recently installed as President of the Ohio Society of Allergy and Immunology. Dr. Ghory is Director of the Division of Allergy/Immunology at Children's Hospital Medical Center.

RICHARD P. LEVY, M.D., Cleveland, has been appointed Director of the Division of Medicine at Canton and Program Director of an Integrated Residency in Internal Medicine, Northeastern Ohio Universities College of Medicine. The programs function under the auspices of the Canton Medical Education Foundation with Aultman Hospital and Timpken Mercy Hospital as the participating institutions. A diplomate of the American Board of Internal Medicine, Dr. Levy comes from his position as Director of the Thyroid Center and Associate Professor of Radiology (Nuclear Medicine) at Case Western Reserve University School of Medicine.

DAVID W. SPRAGUE, M.D., Cleveland, has been named President-Elect of the Central Neuropsychiatric Association. Also elected to office is **THOMAS E. GRETTER, M.D.,** Cleveland, secretary-treasurer of the organization. Founded in 1922, the Association fosters the advancement of neurologic, psychiatric, and neurosurgical sciences in the mid-continental United States.

EDWARD A. SPRAGUE, M.D., Athens, has been elected Chief of Staff at O'Bleness Memorial Hospital. Dr. Sprague has practiced in the Athens area for 30 years. Other officers include **WILLIAM D. JACOBY, M.D.,** Vice Chief, and **JAMES E. MacMILLAN, M.D.,** Secretary.

ANTHONY J. RUPPERSBERG, JR., M.D., Columbus, has been granted emeritus professor status at The Ohio State University College of Medicine. Dr. Ruppersberg has been a faculty member in obstetrics and gynecology at OSU for 25 years. He also is Secretary of the Ohio State Medical Board and Chairman of the OSMA Committee on Maternal and Neonatal Health.

MARK R. TETALMAN, M.D., Columbus, has been named Director, Division of Nuclear Medicine, The Ohio State University College of Medicine. Dr. Tetalman had served as assistant director since 1975.

"Colleagues in the News" is sponsored by

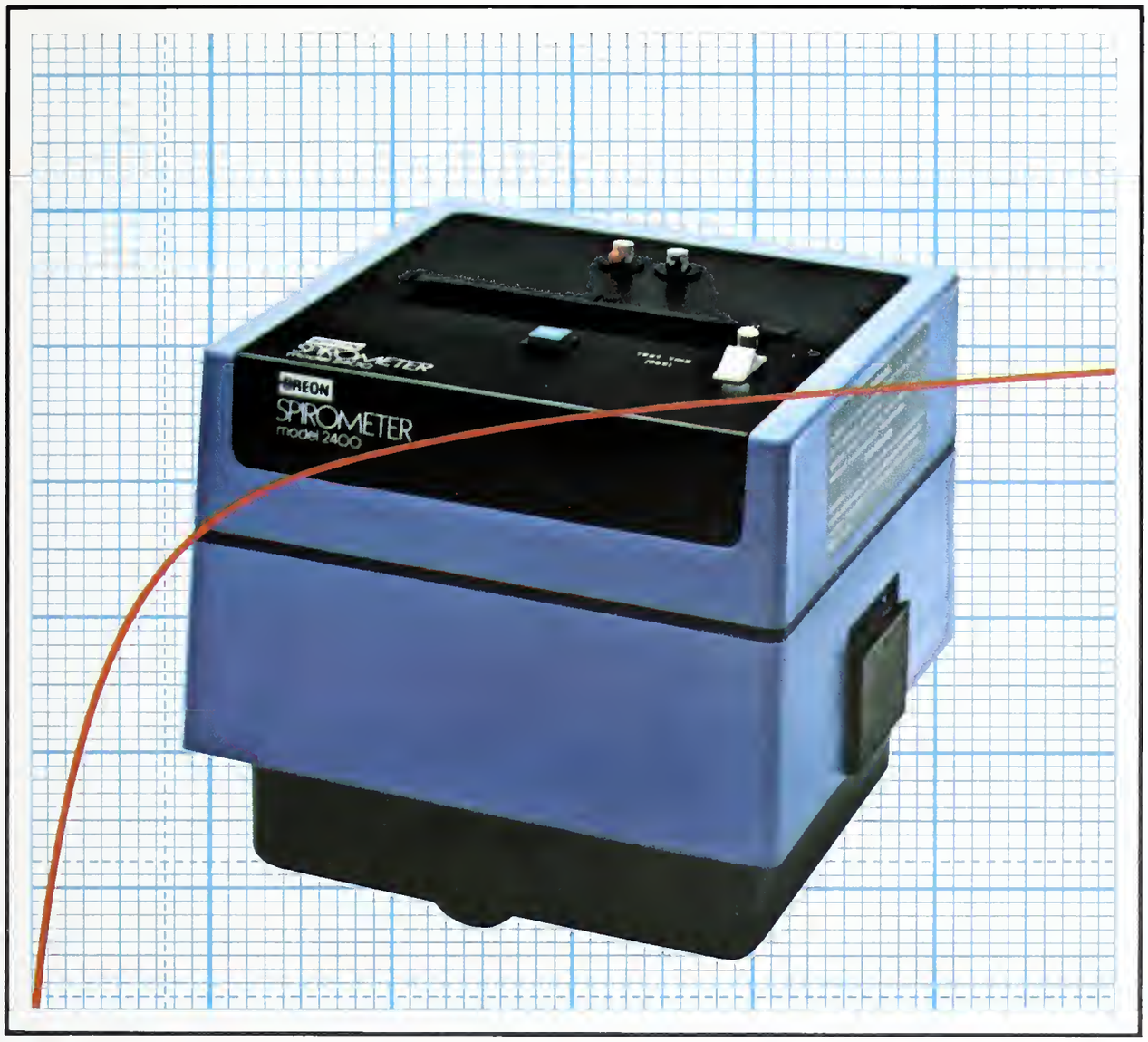


Blue Shield
Ohio Medical Indemnity, Inc.

6740 North High Street, Worthington, Ohio 43085

(614) 438-3500
(PAID ADVERTISEMENT)

SPIROMETRY MADE SIMPLE



Introducing the **BREON**
SPIROMETER
MODEL 2400

- Positive Displacement Direct Reading Spirometer
- Simple to Use
- Easy to Interpret

For more information send in this postage-paid card.

First Class
Permit No.
59720
New York, N.Y.
10016

BUSINESS REPLY MAIL
No postage necessary if mailed in the United States

Postage will be paid by:

Breon Laboratories Inc.
90 Park Avenue
New York, N.Y. 10016

Attn: M. Trepicchio

The BREON SPIROMETER

MODEL 2400

Makes lung function testing easy to interpret.



- Provides a permanent record of results
- A single test provides most common and useful readings.
- ±1% accuracy at full scale
- Weighs less than 10 pounds
- Economical to use

I'd like to know more about office spirometry and the **Breon SPIROMETER Model 2400.**

☐ Please send me more literature.

☐ Please have your representative call.

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____

For more information send in this postage-paid card.

BREON

Breon Laboratories Inc.
90 Park Avenue
New York, N.Y. 10016

Ohio State Medical Association CME Programs

Editor's Note: *The following are Category I courses offered in Ohio. Items for this listing come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in dates, places, or time occur too late to be corrected before publication. Physicians interested in a course are urged to contact the sponsoring organization to confirm the information listed. Sponsoring organizations may list Category I courses by contacting the OSMA Department of Continuing Medical Education or The Journal. Notification 90 days prior to the course would be appreciated. Due to space limitations, announcements may be published only once.* **See previous issues of The Journal for additional courses.**—*L.A.J.*

April 1978

SECOND ANNUAL PAIN UPDATE: April 15 and 16, Stouffers Dayton Plaza Hotel, Dayton; 12 credit hours; fee: $75, no fee residents, interns, medical students of WSU; contact: Arlene L. Polster, Program Coordinator, Wright State University School of Medicine, P.O. Box 927, Dayton 45401, phone: 513/372-7140.

SYMPOSIUM ON GYNECOLOGICAL CANCER: April 19, 8:30 AM; The Conference Center, Holiday Inn— Kent; 8 credit hours; sponsor: Northeast Ohio Gynecologic Cancer Group; cosponsor: Case Western Reserve University; fee: $30 (includes lunch and dinner); contact: The Cancer Center, Inc., 11001 Cedar Avenue, Cleveland 44106, phone 216/421-7300, ext. 205.

EDWARD MACK SYMPOSIUM ON ADOLESCENT HEALTH PROBLEMS: April 20-22, Burr Oak State Park Lodge, Glouster; sponsor: Division of Adolescent Medicine, Department of Pediatrics, Children's Hospital Medical Center; cosponsor: CONMED; 12 credit hours; fee: $125, $75 non-physicians; contact: Office of CONMED, Dean's Suite E251, College of Medicine, 231 Bethesda Avenue, Cincinnati 45267, phone: 513/872-5486.

May 1978

CONTROL OF DIABETES: May 3, Sheraton Dayton Downtown, Dayton; 6 credit hours; fee: $20; contact: Arlene L. Polster, Program Coordinator, Wright State University School of Medicine, P.O. Box 927, Dayton 45401, phone: 513/372-7140.

MANAGEMENT OF UPPER GI BLEEDS: May 9, 7:30 AM; Riverside Methodist Hospital, Columbus; 1 credit hour; contact: Mrs. Joyce Miller or Ms. Karen Saslaw, Riverside Methodist Hospital, 3535 Olentangy River Road, Columbus 43214, phone: 614/261-5428.

PRACTICAL OFFICE DERMATOLOGY: May 10-11; The Cleveland Clinic Foundation, Cleveland; 12 credit hours; fee: $100, $50 students; contact: Center for CME, The Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

ANGLO-AMERICAN CONFERENCE ON HEALTH AND THE FAMILY: May 15-17, Kresge Auditorium, University of Cincinnati; 14 credit hours; fee: $100; contact: Office of CONMED, 231 Bethesda Avenue, Cincinnati 45267, phone: 513/872-5486.



THE OHIO STATE Medical Association Obituaries

JOHN WILLIAM DAVIS, M.D., Painesville; Case Western Reserve University School of Medicine, Cleveland, 1943; age 60; died January 16; member OSMA and AMA.

JOHN T. FUSCALDO, M.D., Tallmadge; West Virginia University School of Medicine, 1963; age 41; died January 25; member OSMA and AMA.

CURTIS JESSE FISHER, M.D., Youngstown; Hahnemann Medical College and Hospital, Philadelphia, 1953; age 51; died January 5; member OSMA and AMA.

DONALD K. MATTHEWS. M.D., Dresden; University of Cincinnati College of Medicine, Cincinnati, 1932; age 76; died February 9; member OSMA and AMA.

JOHN E. MINNS, M.D., Toledo; University of Toronto Faculty of Medicine, Toronto, Ontario, Canada, 1922; age 80; died January 23; member OSMA and AMA.

JOHN ANDREW MITCHELL, M.D., Newark; Cornell University Medical College, New York, New York, 1952; age 55; died January 23; member OSMA and AMA.

MILTON M. PARKER, M.D., PH.D., Columbus; The Ohio State University College of Medicine, 1943; age 63; died March 6; member OSMA and AMA.

The Ohio State Medical Association lost a dedicated leader with the death of Dr. Milton Parker. At the time of his death, Dr. Parker was Chairman of the OSMA Committee on Mental Health, a position he held for nine years. One of the many areas of concern of this committee is the OSMA Physician Effectiveness Program, which was featured in the November 1977 issue of *The Journal.* Dr. Parker was instrumental in compiling this issue and wrote the preface to it.

In addition to his OSMA involvement, Dr. Parker was Assistant Professor of Neurology and Preventive Medicine and Clinical Professor of Psychiatry at The Ohio State University College of Medicine. He was also Chairman of the Department of Psychiatry and Neurology at Riverside Methodist Hospital, Columbus.

LOUIS J. PERME, M.D., Cleveland; Case Western Reserve University School of Medicine, Cleveland, 1923; age 81; died February 9; member OSMA and AMA.

HERMAN D. POCOCK, M.D., Chagrin Falls; Case Western Reserve University School of Medicine, Cleveland, 1916; age 87; died January 25; member OSMA and AMA.

WILLIAM O. RAMEY, M.D., Cincinnati; University of Cincinnati College of Medicine, Cincinnati, 1925; age 81; died January 10; member OSMA and AMA.

ERLING ARNOLD SMEDAL, M.D., Tucson, Arizona; Rush Medical College, Chicago, 1925; age 78; died February 9; member OSMA and AMA.

CLARENCE P. SOMSEL, M.D., Dayton; Eclectic Medical College, Cincinnati, 1937; age 68; died June 20, 1977; member OSMA and AMA.

GEORGE A. TISCHLER, M.D., Cleveland; Case Western Reserve University School of Medicine, Cleveland, 1930; age 73; died February 4; member OSMA and AMA.

WILLIAM W. WEIS, M.D., Piqua; Ohio State University College of Medicine, Columbus, 1923; age 79; died February 17; member OSMA and AMA.

Support OSMA . . .

Pay Your 1978 Dues

Have you paid your medical association dues? If not, this may be the last *Journal* you receive. In May, our mailing list will be cleared of 1977 members who have not renewed in 1978.

The Journal is only one of the benefits of OSMA membership. As a member, you also receive the Association's other publications, including the *OSMAgram* and *Synergy.* These publications highlight the activities planned for members, including continuing education courses, tours, and special programs. In addition, the Association offers a number of insurance programs and one for car leasing.

Equally as important but not as visible is the continued vigilance in support of our physician members in the Ohio Legislature, the U.S. Congress, government medical programs, and public opinion. The Association also is the physician's liaison to such groups as the Ohio State Medical Board and the Ohio State Department of Education, and the OSMA provides on-going personal communication with members through field representatives and membership services.

So, if your dues are not paid, why not write your check for $125 today. To ensure the unity that results from solid membership through county, state, and national support, include AMA dues of $250 in your check. Remember, the achievements of all three are to your advantage. Your support is essential.

"In a major study just completed in Canada, aspirin reduced the chances of stroke in high-risk men—but not in women...A Harvard neurologist urges anticoagulants for patients with atrial fibrillation...Coal strike drives MDs from Appalachia...A mysterious ailment affecting people who live in mobile homes has been traced to formaldehyde used in construction...A University of Wisconsin psychiatrist reports on the effectiveness of jogging for the treatment of depression..."

Important things are happening that you should know about right away. You'll find them on your desk every two weeks in Medical World News, the newsmagazine of medicine.

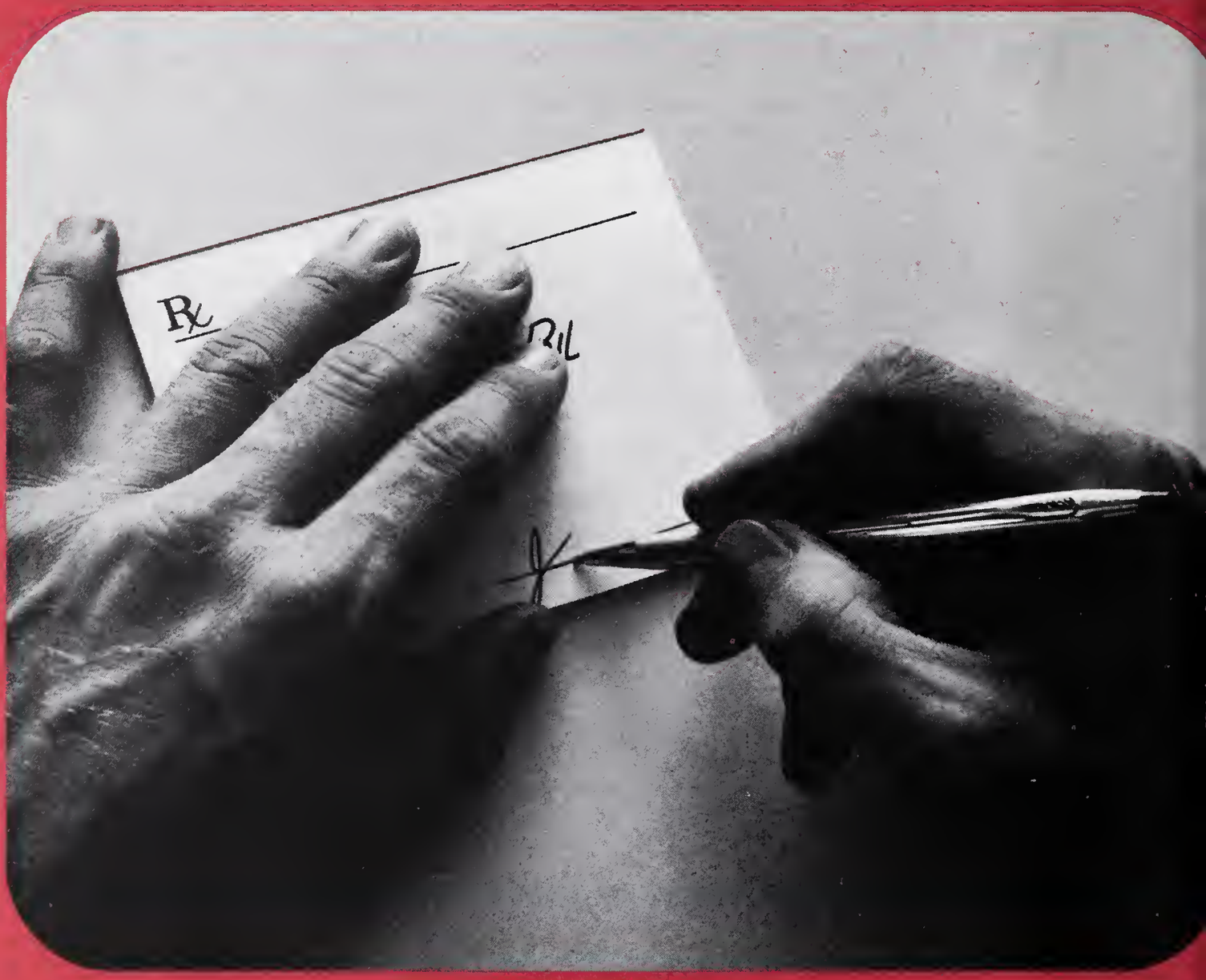
Read this one first.

medical world news

A McGraw-Hill publication

McGraw-Hill

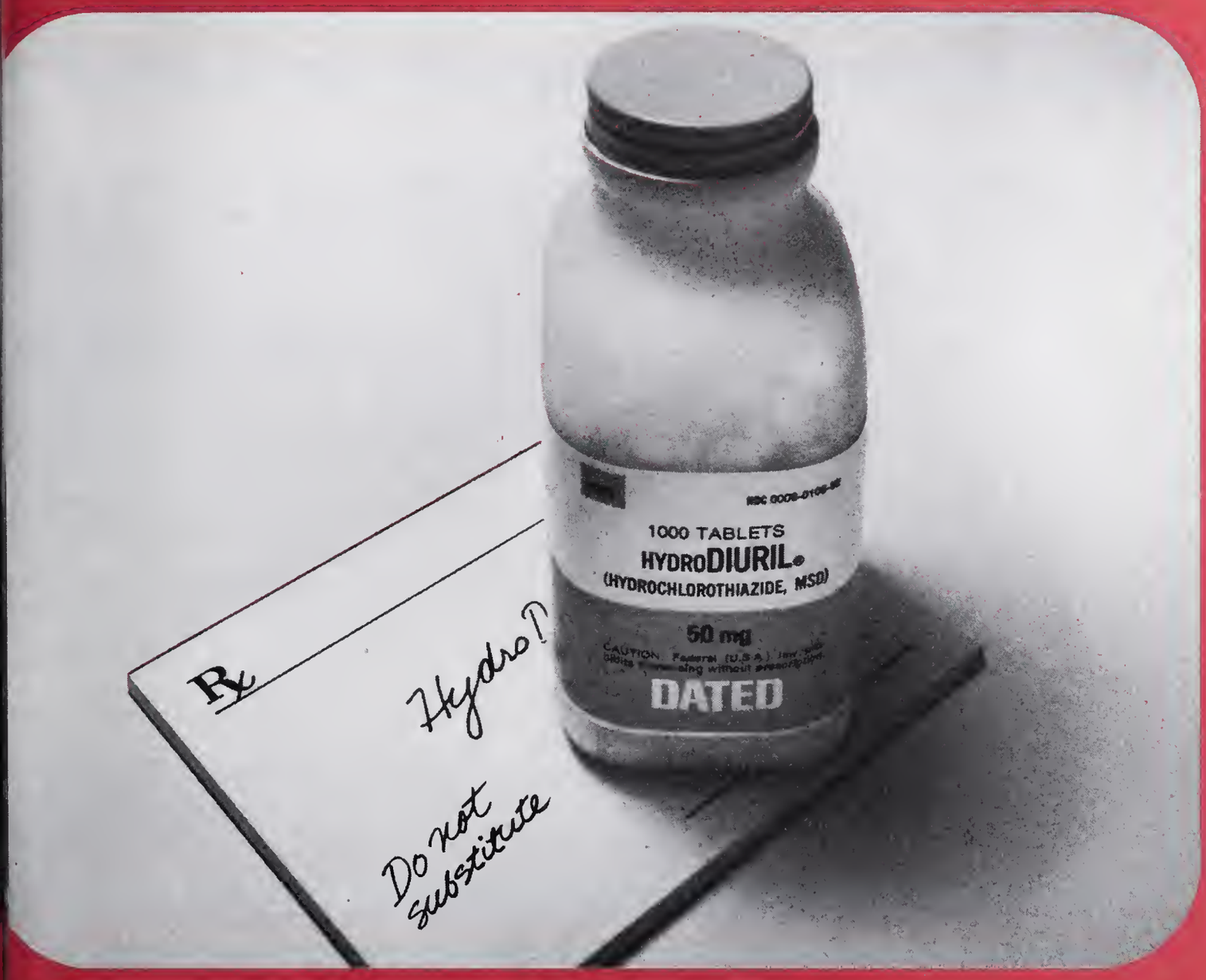
There is no substitute



yours...

Contraindications: Anuria; hypersensitivity to this or other sulfonamide-derived drugs.
Warnings: Use with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects may develop in patients with impaired renal function. Use with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma. May add to or potentiate action of other antihypertensive drugs; potentiation occurs with ganglionic or peripheral adrenergic blocking drugs. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possibility of exacerbation or activation of systemic lupus erythematosus has been reported. Lithium generally should not be given with diuretics because they reduce its renal clearance and add a high risk of lithium toxicity. Read circulars for lithium preparations before use of such concomitant therapy. *Use in Pregnancy:* Thiazides cross placental barrier and appear in cord blood; in pregnancy, weigh anticipated benefit against possible hazards to fetus, including fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions that have occurred in adults. *Nursing Mothers:* Thiazides appear in breast milk; if use of drug is deemed essential, patient should stop nursing.
Precautions: Perform periodic determination of serum electrolytes to detect possible electrolyte imbalance. Observe all patients for clinical signs of fluid or electrolyte imbalance, namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting. Hypokalemia may develop, especially with brisk diuresis in severe cirrhosis, with concomitant corticosteroid or ACTH therapy, with inadequate oral electrolyte intake. Hypokalemia can sensitize or exaggerate response of heart to toxic effects of digitalis (e.g., increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content. Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice.
Hyperuricemia may occur or frank gout may be precipitated in certain patients. Insulin requirements in diabetic patients may be increased, decreased, or unchanged; latent diabetes mellitus may become manifest. Thiazides may increase responsiveness to tubocurarine. Antihypertensive effects of the drug may be enhanced in post-sympathectomy patients. May decrease arterial responsiveness to norepinephrine; this diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use. If progressive renal im-

for experience—



or ours.

irment becomes evident, consider withholding or discontinuing uretic therapy. Thiazides may decrease serum PBI levels without ins of thyroid disturbance. Calcium excretion is decreased by azides. Pathologic changes in the parathyroid gland with hypercemia and hypophosphatemia have been observed in a few patients prolonged therapy; thiazides should be discontinued before testing parathyroid function.

Iverse Reactions: *Gastrointestinal System*—Anorexia; gastric iration; nausea; vomiting; cramping; diarrhea; constipation; jaundice trahepatic cholestatic jaundice); pancreatitis; sialadenitis.

ntral Nervous System—Dizziness; vertigo; paresthesias; headache; nthopsia.

ematologic—Leukopenia; agranulocytosis; thrombocytopenia, lastic anemia.

rdiovascular—Orthostatic hypotension (may be aggravated by ohol, barbiturates, or narcotics).

persensitivity—Purpura, photosensitivity; rash; urticaria; necrotizing giitis (vasculitis) (cutaneous vasculitis); fever; respiratory distress luding pneumonitis; anaphylactic reactions.

her—Hyperglycemia; glycosuria; hyperuricemia; muscle spasm; akness; restlessness; transient blurred vision.

henever adverse reactions are moderate or severe, thiazide dosage ould be reduced or therapy withdrawn.

ote: When used with other antihypertensive drugs, careful observains for changes in blood pressure must be made, especially during tial therapy. Dosage of other antihypertensive agents must be reduced by at least 50 percent as soon as this drug is added to the regimen. As blood pressure falls under the potentiating effect of this agent, further reduction in dosage, or even discontinuation, of other antihypertensive drugs may be necessary

How Supplied: Tablets containing 25 mg hydrochlorothiazide each in bottles of 100 and 1000 and single-unit packages of 100; Tablets containing 50 mg hydrochlorothiazide each in bottles of 100, 1000, and 5000 and single-unit packages of 100; Tablets containing 100 mg hydrochlorothiazide each in bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

J6H004(528)

MSD
MERCK SHARP & DOHME

In hypertension

TABLETS: 25 mg, 50 mg, and 100 mg

HydroDIURIL®

(HYDROCHLOROTHIAZIDE|MSD)

THE OHIO STATE Medical Association Proceedings of the Council

A regular meeting of the Council of the Ohio State Medical Association was held Saturday, February 11, 1978 at the OSMA Headquarters' Office, 600 South High Street, Columbus, Ohio.

ATTENDANCE

OSMA Council present: William M. Wells, M.D., Newark, President; John J. Gaughan, M.D., Cleveland, President-Elect; George N. Bates, M.D., Toledo, Past President; Robert G. Thomas, M.D., Elyria, Secretary-Treasurer; Stewart B. Dunsker, M.D., Cincinnati, First District Councilor; W. J. Lewis, M.D., Dayton, Second District Councilor; Alford C. Diller, M.D., Convoy, Third District Councilor; C. Douglass Ford, M.D., Toledo, Fourth District Councilor; Theodore J. Castele, M.D., Cleveland, Fifth District Councilor; C. Edward Pichette, M.D., Youngstown, Sixth District Councilor; Robert E. Rinderknecht, M.D., Dover, Seventh District Councilor; Richard E. Hartle, M.D., Lancaster, Eighth District Councilor; Thomas W. Morgan, M.D., Gallipolis, Ninth District Councilor; J. Hutchison Williams, M.D., Columbus, Tenth District Councilor; S. Baird Pfahl, Jr., M.D., Sandusky, Eleventh District Councilor; and William Dorner, Jr., M.D., Akron, Twelfth District Councilor.

Guests present: John H. Ackerman, M.D., Columbus, Director, Ohio Department of Health; James E. Pohlman, Esq., Columbus, OSMA Legal Counsel; and Joseph K. Gilmore, Columbus, President, Physicians Insurance Company of Ohio.

Present and representing MAI: William R. Schultz, M.D., Wooster; Edward A. Lentz, Columbus; and Alfred F. Hartmann, Columbus.

OSMA Staff present: Hart F. Page, Charles W. Edgar, Herbert E. Gillen, Jerry J. Campbell, Robert D. Clinger, Katherine E. Wisse, D. Brent Mulgrew, Robert E. Holcomb, Gail E. Dodson, Rebecca J. Doll, Richard A. Ayish, David C. Torrens, and Judy Franklin.

ADMINISTRATION DEPARTMENT

The minutes of the December 17, 1977 meeting of the Council were **approved.**

The Council adopted the following statement concerning the weather crisis in January:

Commendation of the Honorable James A. Rhodes, Governor of Ohio

WHEREAS, on January 26-27, 1978, Ohio was paralyzed by one of the most dangerous and brutal blizzards in the history of the United States, and

WHEREAS, said blizzard critically threatened the health, safety, general welfare and the very lives of untold thousands of Ohioans, and

WHEREAS, the Honorable James A. Rhodes, Governor of Ohio, moved swiftly and effectively to initiate and personally supervise a statewide program that prevented panic, rescued the imperiled and brought medical assistance, food, and other aid and comfort to thousands of Ohioans, and

WHEREAS, Governor Rhodes' actions vividly demonstrated outstanding leadership as well as very deep personal compassion and concern for his fellow man, THEREFORE BE IT

RESOLVED, that the Ohio State Medical Association expresses great appreciation and commendation to Governor Rhodes for his outstanding humanitarianism, AND BE IT

FURTHER RESOLVED, that this Association also expresses its great appreciation and commendation to the hundreds and hundreds of unsung heroes among state employees, the military, the private citizenry and the medical care providers of Ohio who gave so unselfishly and tirelessly of their own in carrying out thousands of missions of mercy.

The Council **approved** arrangements to rent office space and other facilities to the Executive Director of the Ohio Ophthalmological Society and to pay salary and other administrative expenses for reimbursement by the Society.

The Council received a communication from Richard F. Slager, M.D. and Harry J. Shaver, M.D., nominating Sol Maggied, M.D., West Jefferson, for President-Elect of the Ohio State Medical Association.

The Council **approved** the formation, in cooperation with the Ohio Hospital Association, of a broad spectrum organization to deal with problems of health care costs.

FINANCIAL AND MEMBERSHIP DEPARTMENT

Membership statistics presented by Mrs. Wisse indicated a gain of 939 members over January 31, 1977.

Committee on Auditing and Appropriations

The minutes of a meeting of the Committee on Auditing and Appropriations held February 10, 1978 were presented by Dr. Rinderknecht and **were approved.** Included in the approval was an authorization to contract for an initial systems analysis with a Columbus firm chosen to write the software and assist in selection of hardware for the Association requirements.

The Council also ordered detailed drawings for the renovation of the property at 618 South High Street, contingent upon zoning clearance and other contractural details.

DEPARTMENT OF CONTINUING MEDICAL EDUCATION

Committee on Education

Mrs. Dodson presented the minutes of the January 12, 1978 meeting of the Committee on Education.

The Council voted to advise the American Medical Association that membership in the National Council of

State Committees of Continuing Medical Education is not desirable or necessary at this time and that the purposes and functions of the proposed organization could better be accomplished through LCCME whose authority was delegated by the AMA Council on Medical Education.

A list of recipients of Category 1 **was approved** and the survey report form adjustments were endorsed by the Council.

The Council **approved** methodologies for meeting Category 1 to all organizations already accredited and to new organizations accredited in the future.

The report as a whole **was approved.**

State Medical Board

Mrs. Dodson reported on a February 8 meeting of the Ohio State Medical Board, which was also attended by Dr. Wells, Mr. Page and Mr. Mulgrew. She stated that the Ohio State Medical Board made a ruling that Category 1 CME hours be acceptable certified either by the OOA or OSMA for holders of D.O. and M.D. degrees.

The decision means that a physician holding an M.D. degree can turn in to the Board hours certified by the OOA as Category 1 to meet the requirements of 60 hours Category 1 in a triennium; a physician with a D.O. degree can submit to the Board hours certified by the OSMA as Category 1 CME hours.

1978 Annual Meeting

It was voted that the 1978 Annual Meeting honor John H. Budd, M.D., Cleveland, President of the American Medical Association, and that the Council introduce a resolution conferring upon Dr. Budd the honorary presidency of the Association for 1978-1979.

The Council voted to select Past-President Robert N. Smith, M.D., Toledo, an anesthesiologist and recently the U.S. Assistant Secretary of Defense for Health Affairs, to receive the OSMA 1978 Distinguished Service Citation.

GOVERNMENT MEDICAL CARE DEPARTMENT

Ohio Medical Indemnity, Inc.

Mr. Gillen reported on the January 25, 1978 meeting of the Board of Directors of Ohio Medical Indemnity, Inc.

Planning Guidelines

The Council discussed the second edition of the National Guidelines for Health Planning. These guidelines were issued through the January 20 Federal Register after the original guidelines, published September 23, 1977, were withdrawn following objection from the Ohio State Medical Association and a host of other organizations. The Council **approved** a draft of a statement addressed to the Office of Planning, Evaluation and Legislation of the Health Resources Administration, from President Wells, expressing OSMA objections to the new guidelines because of their mandatory nature and asked that they, too, be withdrawn.

(continued on page 273)

When was the last time your practice gave you a good night's sleep?

We're not talking about sleep that comes from sheer exhaustion.

We're talking about the kind of sleep that comes from knowing you practiced medicine today the way it was meant to be practiced. Of giving your patients the very best in medical care. With no compromises.

And a sleep that comes from knowing you won't be spending all of tomorrow morning filling out Medicare insurance forms, or attending to a myriad of other time-consuming, nonmedical duties.

But there is a practice that offers an alternative to the kind of medicine you're now practicing. A practice in the U.S. Navy.

The Navy physician.

As a Navy physician, we feel your time is too valuable to spend on administrative details. So they're kept to a minimum. Instead, a highly trained staff of professionals attends to the paperwork. The end result is that almost all your time can be spent practicing medicine.

A challenging practice.

You'll be given a practice that's as varied and challenging as any you'll find in a civilian setting. You'll be treating active duty personnel as well as their dependents and retired personnel.

Insurance.

A recent Act of Congress now makes it unnecessary for federally employed physicians to carry high cost insurance. As a practicing Navy physician, you will receive professional liability protection under the Federal Tort Claims Act.

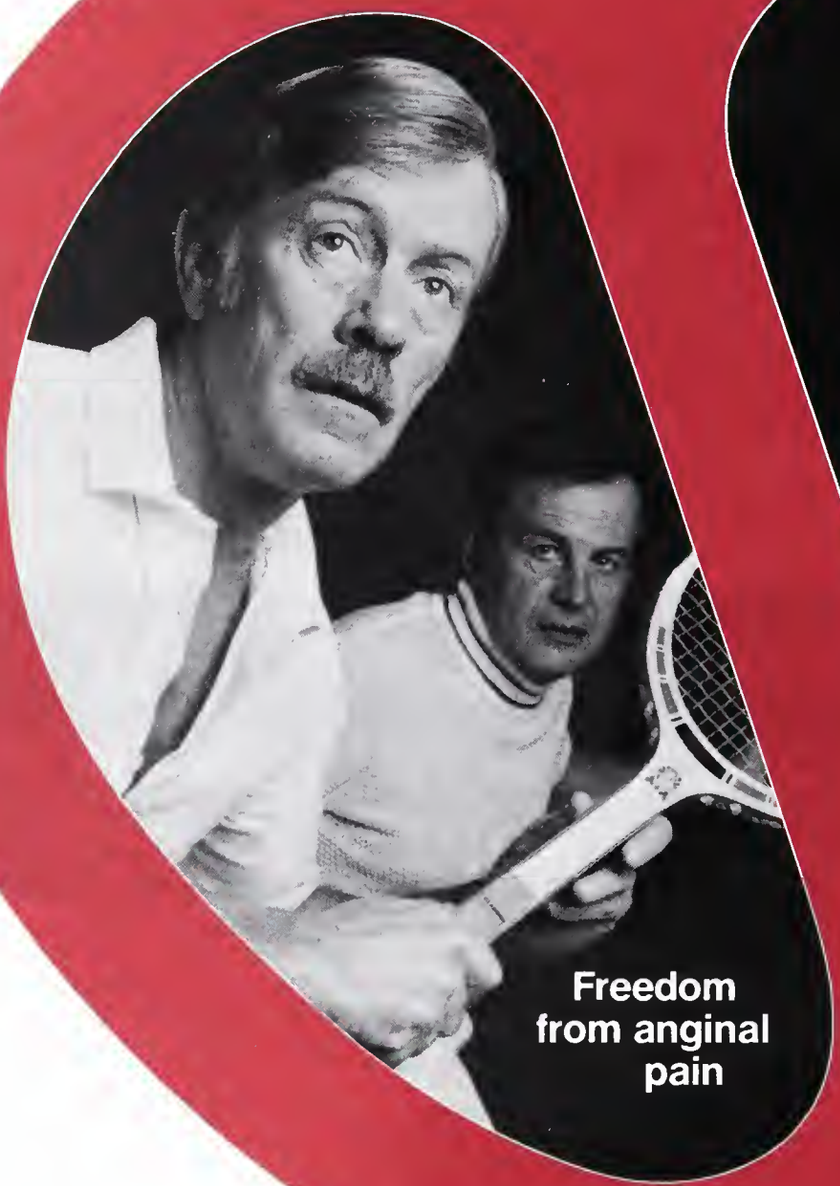
Other benefits.

There are plenty of other great benefits that go with being a Navy physician. Good pay— $30,000 to start, more, depending on your experience. A family life with time for your family. Associating with other highly motivated physicians. Even 30 days' paid vacation a year.

But the best way to get all the facts is to mail the coupon, or call the Medical Recruiter, toll-free, 1-800-282-1288.

Be the doctor you want to be. In the Navy.

Angina freedom fighter...



Freedom from anginal pain



Freedom from anginal fear

1. Taken sublingually, Cardilate® (erythrityl tetranitrate) begins to work within 5 minutes, eliminating or reducing frequency and severity of anginal pain for up to two hours.
2. Fear of pain, a major deterrent to achieving acceptable (and desirable) levels of activity, including sex, may be allayed with Cardilate. Effective prophylaxis and improved exercise tolerance help toward normalizing the lives of anginal patients.

Cardilate®
(erythrityl tetranitrat

Cardilate® (erythrityl tetranitrate)
INDICATIONS: For the prophylaxis and long-term treatment of patients with frequent or recurrent anginal pain and reduced exercise tolerance associated with angina pectoris, rather than for the treatment of the acute attack of angina pectoris, since its onset is somewhat slower than that of nitroglycerin.

PRECAUTIONS: As with other effective nitrites, some fall in blood pressure may occur with large doses.

Caution should be observed in administering the drug to patients with a history of recent cerebral hemorrhage, because of the vasodilation which occurs in the area. Although therapy permits more normal activity, the patient should not be allowed to misinterpret freedom from anginal attacks as a signal to drop all restrictions.

SIDE EFFECTS: No serious side effects have been reported. In sublingual therapy, a tingling sensation (like that of nitroglycerin) may sometimes be noted at the point of tablet contact with the mucous membrane. If objectionable, this may be mitigated by placing the tablet in the buccal pouch. As with nitroglycerin or other effective nitrites, temporary vascular headache may occur during the first few days of therapy. This can be controlled by temporary dosage reduction in order to allow adjustments of the cerebral hemodynamics to the initial marked cerebral vasodilation. These headaches usually disappear within one week of continuous therapy but may be minimized by the administration of analgesics.

Mild gastrointestinal disturbances occur occasionally with larger doses and may be controlled by reducing the dose temporarily

HOW SUPPLIED: 10 mg chewable scored tablets, bottle of 100. Also 5, 10 and 15 mg oral/sublingual scored tablets in bottles of 100. 10 mg oral/sublingual scored tablets also supplied in bottles of 1,000.

Also available: Cardilate®-P brand Erythrityl Tetranitrate with Phenobarbital* Tablets (Scored).

(*Warning—may be habit-forming.)



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709
Wellcome

Proceedings *(continued)*

Government Verification Program/Medicare Payments

The Council ratified and affirmed President Wells' letter of February 3, 1978 to HEW Secretary Califano pointing out that the Government's Verification Program/Medicare Payments is a wasteful expenditure of government money which has no redeeming value and urging that the program be withdrawn and cancelled.

The Council received for information a letter to all members dated February 3, 1978 discussing the program and enclosing a copy of the letter to Secretary Califano asking that the program be cancelled.

Ohio Health Data Corp., Inc.

Drs. Diller and Hartle and Mr. Gillen reported on the organization meeting of the Ohio Health Data Corporation.

VA Fee For Service Program

Mr. Gillen and Mr. Page reported on a meeting with Dr. Charles Block, Chief of the Veterans Administration Outpatient Department, with regard to developments in the VA Fee for Service Program.

OHIO DIRECTOR OF HEALTH

Dr. John H. Ackerman, Ohio Director of Health, reported on an outbreak of influenza in Ohio and stated that the Department would soon determine the strain involved.

He discussed problems involved with the Administration of Health Planning and expressed appreciation to the physicians in Ohio for their fine work during the weather crisis.

DEPARTMENT OF ORGANIZATION SERVICES

American Medical Association

Mr. Campbell announced that efforts with regard to Dr. Oscar W. Clarke's candidacy for Council on Medical Service were going forward.

It was announced that the AMA is holding a meeting in Chicago, April 10, involving the AMA Delegates, Alternate-Delegates, State Presidents, Presidents-Elect and Executive Directors from 7 states: Illinois, Indiana, Iowa, Michigan, Minnesota, Ohio and Wisconsin. Much of the session would be devoted to voluntary cost containment and the Cost Commission Report. Other topics include: Joint Commission on Accreditation of Hospitals, Membership Projects and Plans, Legislative Assessment and Procedures of the House of Delegates. The Council voted to support the meeting and encouraged attendance. It also requested financial assistance in sending representatives to the meeting, since this program was unanticipated and was therefore not included in the AMA delegation budget.

PICO

Mr. Joseph K. Gilmore, President of the Physicians Insurance Company of Ohio, discussed proposed amendments to the PICO Code of Regulations to enable the

(continued on next page)

Company to enter into a joint venture with the Kentucky Medical Association to assist Kentucky physicians with the formation of a "captive" malpractice insurance company to serve physicians in that state. PICO would sell insurance to Kentucky physicians during the period that the Kentucky Medical Association raises the necessary capital to form its own "captive" company and would also provide management services. Mr. Gilmore reported that a special meeting of the shareholders of PICO to amend the Code of Regulations has been set for March 2, 1978.

After extensive study of the matter, the Council voted unanimously to cast the OSMA votes to amend the Code of Regulations. Dr. Wells was selected to vote the Class B shares of PICO owned by the Ohio State Medical Association at the special meeting of the shareholders, with Mr. Page as the alternate.

PICO Life Insurance

Mr. Gilmore led a discussion of the formation of a wholly owned PICO subsidiary to write life insurance. It was the unanimous decision of the Council to cast the OSMA votes at the special shareholders meeting in favor of the proposal to form the life insurance company subsidiary, in order to strengthen PICO and make it better able to serve Ohio physicians' needs for insurance coverage.

Task Force on Professional Liability

The minutes of a February 8 meeting of the OSMA Task Force on Professional Liability were presented by Mr. Campbell and **were approved.**

DEPARTMENT OF HEALTH EDUCATION

Joint Advisory Committee on Sports Medicine

The minutes of the meeting of the Joint Advisory Committee on Sports Medicine, held January 14-15, were presented by Mr. Clinger.

The following concept with regard to pre-participation physical examinations in interscholastic athletics **was approved** and the Council added the language that such examinations should be done by licensed physicians (doctors of medicine or doctors of osteopathic medicine and surgery):

> A pre-participation medical examination by a licensed physician (M.D. or D.O.) should be required upon a student athlete's initial entrance into an interscholastic athletic program. The examination should include a review of the athlete's health history and a relevant general and orthopedic physical examination.
>
> Medical records maintained during the student's scholastic career should include a record of injuries and illness sustained during the competitive season and off-season, medical referrals, subsequent care and clearances, and a completed yearly health status questionnaire.
>
> Provided there is a continuous awareness of the health status of the athlete, the traditional pre-participation physical examination each year for all student athletes is not necessary.

The report, as a whole, **was approved** as amended.

DEPARTMENT OF FEDERAL LEGISLATION AND PUBLIC POLICY

Mr. Edgar indicated that hearings would be held soon on H.R. 10460, to extend and amend Public Law 93-641, the Health Planning Act. He announced that a delegation from the Ohio State Medical Association would be calling on members of the Interstate and Foreign Commerce Committee in Washington on February 21. He reviewed a dozen or more amendments which would be requested by the Association. The Council voted to oppose the bill unless it is properly amended.

DEPARTMENT OF STATE LEGISLATION

Mr. Mulgrew reviewed S.B. 349, the certificate of need bill, and H.B. 490, to set up a health care financing department to take over the health care programs presently in the State Departments of Health and of Public Welfare. He discussed OSMA action on these bills. He also reviewed H.B. 687, legislation that will change the time for the gonorrhea test of pregnant women and our continuing opposition to S.B. 163, a bill that permits optometrists the use of "diagnostic drugs."

Mr. Mulgrew indicated that legislation with regard to a Department of Health radiation control program has been introduced (HB 1075, Eckert, D-Cleveland).

An Annual Meeting program on legislation was discussed and the Council expressed the opinion that it should be in the form of a seminar rather than a general session. The session was scheduled 1:30-3 PM on Monday, May 8.

The Council discussed the matter of socio-economic and legislative activity of various specialty organizations and how best to coordinate this activity. The subject was referred for study to the Auditing and Appropriations Committee.

Committee on Prisons and Jails

Mr. Ayish requested, and received the Council's authority to proceed with negotiations with the American Medical Association regarding a proposal involving a pilot program on prisons and jails accreditation in Ohio.

COMMUNICATIONS DEPARTMENT

Ms. Doll reported that the following Communications Seminars are to be sponsored by the Ohio State Medical Association: Athens, March 8 & 9; Dayton, March 22 & 23; Cleveland, March 29 & 30; and Toledo, April 12 & 13.

She announced that Dr. Castele's radio program has been syndicated nationally by OSMA and AMA in cooperation with Scripps Howard.

FIELD SERVICE DEPARTMENT

Mr. Holcomb reported on field visits to county medical societies.

Dr. Williams and Mr. Holcomb presented the following report of the Ad Hoc Committee on Creation of a Resident Physicians Section of the OSMA:

> The members of the committee initially restated that the

postgraduate medical students in this state have a genuine interest in the business of organized medicine within this state and the nation and see the need for solidarity within the medical profession.

The committee has met twice and has received a report from two of its resident physician members who attended the American Medical Association Resident Physician Section Interim Business Meeting, December 2-3, 1977. Both committee members talked with resident physicians from other states to learn the approach that had been used in these other states to create a Resident Physician Section.

Findings: The committee unanimously concluded any proposed change to the OSMA Constitution and Bylaws would be premature at this time and suggests the following:

1. A liaison committee of resident physicians be appointed by the President of OSMA with representation from each of the Councilor Districts (No.'s 1, 2, 4, 5, 6, 10, 12) where postgraduate medical programs originate;
2. The liaison committee establish communications with the house staffs in each District to assess resident opinion regarding interest and issues and structure of a Resident Physician Section;
3. The liaison committee present structure of Resident Physician Section for approval at the OSMA House of Delegates meeting in 1979;
4. County medical societies be encouraged to provide for Postgraduate Year ONE (PG-1) membership;
5. County medical societies engender interest from their members-in-training in the activity of the society's OSMA Delegates.

COUNCILOR REPORTS

Councilors reported on activities in their districts.

LEGAL COUNSEL REPORT

The matter of a request for a list of the names and addresses of county delegates to the Ohio State Medical Association House of Delegates was brought before the Council. The problem of indiscriminate use of such lists and the imposition of mass mailings upon the delegates and members was considered. The Council decided to adopt a policy that such lists and similar materials from OSMA files would be made available to members of the Ohio State Medical Association upon request, contingent upon the member's agreement that such materials would be for his personal use in connection with the activities and work of OSMA and would not be made available by him in whole or in part to other individuals, firms, corporations, associations or government agencies for any other purpose.

CONSTITUTION AND BYLAWS

Amendments to the Constitution and Bylaws of the Ross County Medical Society and the Licking County Medical Society **were approved.**

Dr. Dorner raised the problem of mandatory revocation of membership when a physician's license is temporarily suspended during rehabilitation or when he has a temporary lapse of licensure because of difficulty in the triennial relicensure procedure. It was the consensus that these problems should have attention at the forthcoming Annual Meeting of the Ohio State Medical Association and Dr. Dorner was encouraged to work with the Summit County Medical Society in developing resolutions on these subjects.

SUMMER RESIDENCY PROGRAM

Mr. Page brought to the attention of the Council the AMA-Northwestern University Masters Program in Medical Society Management. The Council authorized him to advise the American Medical Association that the Ohio State Medical Association will cooperate with the program by accepting a student for a three-months' summer residency at the Ohio State Medical Association.

MEDICAL BOARD ROSTER

Letters of complaint concerning omission of names from the 1975 Roster of Registered Physicians in the State of Ohio were presented to the Council. Mr. Page announced that the 1977 Roster has been published and that the Medical Board would be mailing it to all registered physicians within a short time.

LETTER RE BILLING PROCEDURES

A letter from Dr. Daniel Desberg, of Beachwood, Ohio, regarding billing procedures was referred to the Committee on Judicial and Professional Relations.

There being no further business, the Council meeting was adjourned.

ATTEST: Hart F. Page, CAE
Executive Director

Letters to the Editor

To the Editor:

The *Beacon Journal's* (Akron, Ohio) Action Line column solves problems and answers questions for readers.

An Action Line reader has written to us asking if we can help her find a medical center or hospital in the United States that treats or researches cavernous malformation of the portal vein.

Any help on this matter that you can give us will be greatly appreciated.

s/Kathy Goforth
Chief of Staff
Action Line

To the Editor:*

I am very grateful for your having sent me a copy of *The Ohio State Medical Journal* with the OSMA report in it.† I think it is a very effective one and I am very pleased to see your program going so well; and I am also pleased that my friend Dr. Hoyt has such a big part in it.

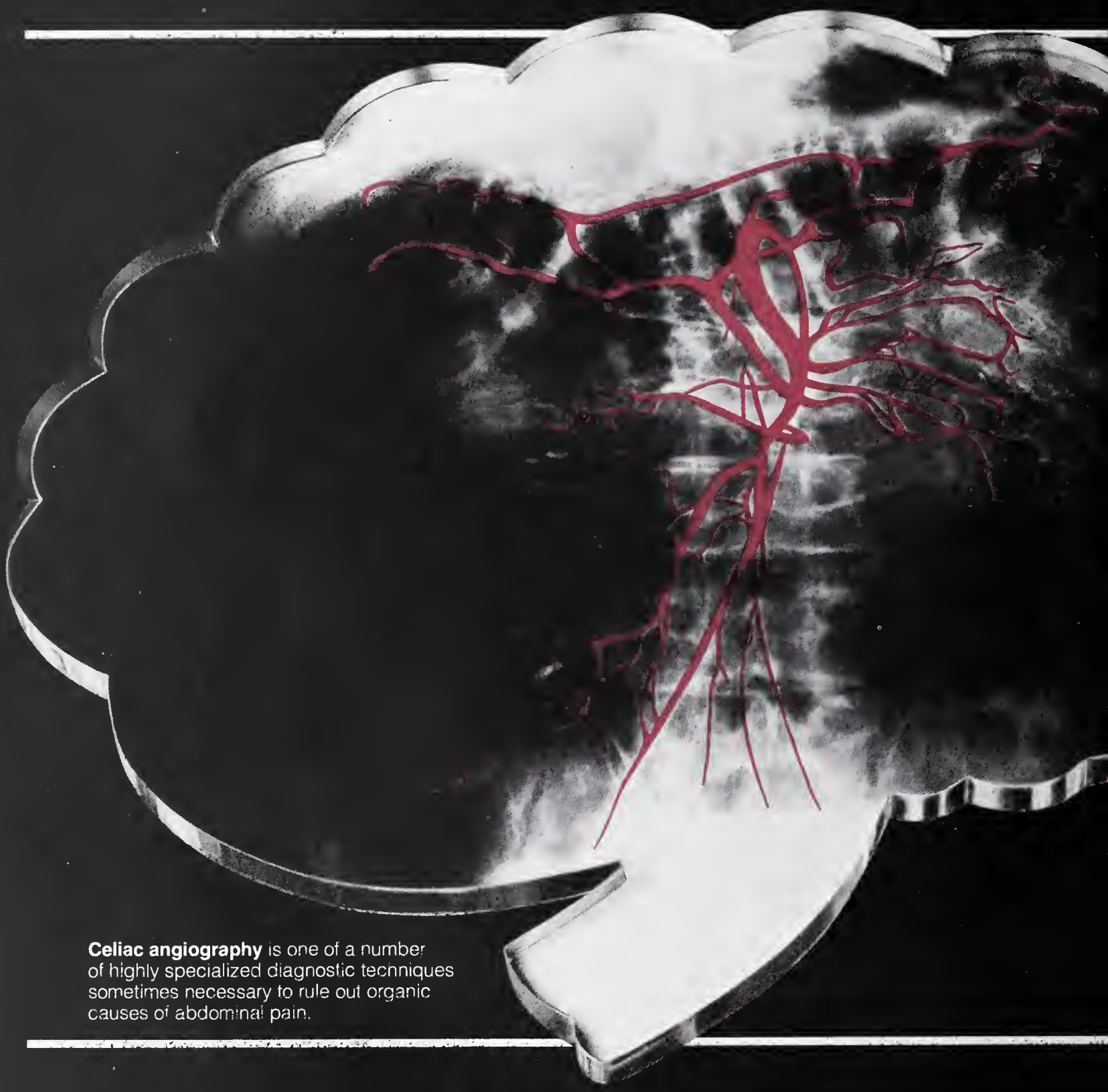
With your permission, through the *Journal* and the *Physician's Alcohol Newsletter*, I am going to let the rest of the AMSA world know of this publication.

s/Frank A. Seixas, M.D.
Medical Director
National Council on Alcoholism

*Letter received by Robert D. Clinger, OSMA Associate Executive Director.

†Volume 73, No. 11, November 1977.

THE LOWER G.I. TRACT: ORGANICALLY SOUND



Celiac angiography is one of a number of highly specialized diagnostic techniques sometimes necessary to rule out organic causes of abdominal pain.

..BUT OVERSENSITIVE TO EMOTIONAL STRESS



IN IRRITABLE BOWEL SYNDROME* LIBRAX PROVIDES DISTINCTIVE ADVANTAGES

- the specific antianxiety action of Librium® (chlordiazepoxide HCl)
- the potent antispasmodic action of Quarzan® (clidinium Br)

Adjunctive/Dual-Action

LIBRAX®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br

A clear treatment advantage for patients with irritable bowel syndrome

ROCHE

*This drug has been evaluated as possibly effective for this indication.
Please see following page for brief summary of prescribing information.

A CLEAR TREATMENT ADVANTAGE FOR PATIENTS WITH IRRITABLE BOWEL SYNDROME*



Adjunctive/Dual-Action LIBRAX®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

ONLY LIBRAX PROVIDES THE SPECIFIC ANTIANXIETY ACTION OF LIBRIUM® (chlordiazepoxide HCl) PLUS THE POTENT ANTISPASMODIC ACTION OF QUARZAN® (clidinium Br)

Please consult complete prescribing information, a summary of which follows:

* **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium® (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacologic effects of agents, particularly potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are avoidable in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of the mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

Dosage: Individualize for maximum beneficial effects. Usual maintenance dose is 1 or 2 capsules, 3 or 4 times a day, before meals and at bedtime. Geriatric patients—see Precautions.

How Supplied: Librax is available in green capsules, each containing 5 mg chlordiazepoxide hydrochloride (Librium®) and 2.5 mg clidinium bromide (Quarzan®)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50, available singly and in trays of 10.

ROCHE

Roche Products Inc.
Manati, Puerto Rico 00701

Classified Ads

Rates: $3 per line. Display classified: $5 per line. Minimum 3 lines per insertion. Ads measure 8 lines to the inch. Box number reply: Flat $5 charge in addition to line cost for up to and including three insertions. (Covers cost of mailing replies which are kept confidential.) Forms close the 10th day of the month preceding month of publication. Address all ads Attention: Classified Ad Department, ***The Journal.***

To assure prompt delivery, when replying to an advertisement over a ***Journal*** box number, address letters as follows: Box (insert number), c/o ***The Ohio State Medical Journal***, 600 South High Street, Columbus, Ohio 43215.

EMERGENCY PHYSICIANS: Directorship and two staff positions open in the Emergency Department of our North Central Ohio community hospital. Excellent salary and fringe benefit package available for the right physicians. Upper-middle-class community offers excellent setting for recreation and travel to and from Cleveland and Toledo. Send resume, along with information on availability dates, to Box 827 c/o Ohio State Medical Journal.

GENERAL MEDICAL OFFICE: Available for rent. Fully equipped, ready for occupancy in CIRCLEVILLE, OHIO. General or internal medicine, eye, ENT, general surgery. Excellent opportunity, accredited 60-bed local hospital with new construction underway. Only 25 miles south of Columbus. Contact: Robert G. Smith, M.D., 214 E. Franklin St., Circleville, Ohio, phone: 614/474-2124 or 474-5680.

PATHOLOGIST: Board certified. Seeking part-time position. Contact: Thomas P. Forrestal, M.D., 2236 Maple Avenue, Zanesville, Ohio 43701, phone: 614/454-8534.

FOR SALE: Modern medical office building, Warren, Ohio. One floor, 4,200 sq. ft., 30 parking spaces. Excellent location one block from hospital. Air conditioned. Excellent for any profession or business. Serious inquiries only to 1621 E. Market St., Warren, Ohio 44483, phone: 216/393-2583.

INTERNISTS FOR PRIMARY CARE UNIT: Hospital-based practice in Ann Arbor, Michigan available July 1, 1978. Faculty appointment with house staff teaching through affiliation with the University of Michigan. Salary to $40,000 plus, depending on qualifications, with Federal Civil Service benefits. An equal employment opportunity employer. Please send C.V. to Associate Chief of Staff for Ambulatory Care, VA Hospital, 2215 Fuller Road, Ann Arbor, Michigan 48105.

OFFICE FOR RENT: Retired physician has office for rent in Delaware, Ohio. Furnished or unfurnished. Call for details. Phone: 614/369-8398.

MEDICAL DIRECTOR: For new VA Outpatient Clinic opening in Toledo, Ohio, September 1978. Desire ABIM and demonstrated administrative ability. Salary to $50,000, depending on qualifications, with Federal Civil Service benefits. An equal employment opportunity employer. Please send C.V. to Associate Chief of Staff for Ambulatory Care, VA Hospital, 2215 Fuller Road, Ann Arbor, Michigan 48105.

PSYCHIATRY RESIDENT

Position available for a first-year resident in psychiatry to last one year. Successful candidate must have graduated from an approved medical school.

Salary commensurate to other first-year resident positions. Hours to vary with department requirements.

Forward credentials, with references, to:

J. P. Duffy, M.D.
Department of Psychiatry
Hanna Pavilion
University Hospitals of Cleveland
2040 Abbington
Cleveland, Ohio 44106

Equal Opportunity Employer M/F

INTERNISTS-FAMILY PRACTITIONERS: Positions available September 1, 1978 at new VA Outpatient Clinic located in Toledo, Ohio. Salary to $40,000 plus, depending on qualifications, with Federal Civil Service benefits. An equal employment opportunity employer. Please send C.V. to Associate Chief of Staff for Ambulatory Care, VA Hospital, 2215 Fuller Road, Ann Arbor, Michigan 48105.

AMBULATORY CARE CENTER — EMERGENCY DEPARTMENT STAFF PHYSICIAN, ATHENS, OHIO: 20,000 annual patient visits. Flexible scheduling, minimum guarantee/monthly bonus, excellent fringes. Contact Eric Jenison, M.D., O'Bleness Memorial Hospital, Athens, Ohio 45701, or call toll-free 800/325-3982 for details.

(Classified Ads continued on page 280)

MEDICAL DIRECTOR: Full-time, for PSRO — Area 12; Ohio Cuyahoga County (Cleveland) — Send curriculum vitae to Robert A. Hahn, M.D., 14701 Detroit Avenue, Suite 450, Lakewood, Ohio 44107.

RADIOLOGIST

Seventy-bed, not-for-profit community hospital in North Central Ohio is currently seeking a Staff Radiologist, effective immediately. Excellent growth potential in a department now at 15,500 procedures annually and with new Nuclear Medicine equipment. Superior position for associate or junior member of an existing corporation to have your own radiology department. Must be board certified or eligible in general Radiology and Nuclear Medicine. Send current, detailed curriculum vitate to Box 824, c/o Ohio State Medical Journal.

OB/GYN: Incorporated obstetrics/gynecology group seeking an additional member. Suburb of medium-size city, midwestern Ohio. Please send curriculum vitae and request for additional information to Box 825 c/o Ohio State Medical Journal.

FOR LEASE: Modern 2,125 sq. ft. medical clinic. Six examining rooms, x-ray room, laboratory, private office, business office. Adjacent to pharmacy in Richfield, Ohio. $850 per month. Long-established family practice has been abandoned. Contact Charles Clucas at 216/659-4101.

UROLOGIST: FMG, board certified, university trained. FLEX. Seeks solo or group practice. Available July 1978. Contact Box 826 c/o Ohio State Medical Journal.

PSYCHIATRY STAFF OPENING: Board-eligible or board-certified Psychiatrist in a reorganized service of outpatient-inpatient programs with 479 operating psychiatric beds and 40,000 outpatient visits. The environment is healthy; work standards high. An unusual opportunity for personal development and individual contributions to organizational upgrading. USCSC fringe benefits. Nondiscriminating in employment. Send application and resume to Chief of Staff, Paul F. Fletcher, M.D., VA Hospital, Chillicothe, Ohio 45601; Telephone 614-773-1141.

SITUATIONS WANTED: Obstetrician/gynecologist and surgeon. Wife and husband both board eligible. No preference as to type of practice or location. Available July 1978. Reply Box 823 c/o Ohio State Medical Journal or call 212/254-1329, evenings and nights.

FOR RENT: Modern offices — 900-1400 sq. ft., A/C, free parking, on bus lines, between two hospitals. Contact Mrs. L. Patrick, 9524 Bohning Dr., Garfield Heights, Ohio 44125 (Cleveland suburb). Phone 216-883-4575.

ORTHOPEDIST WANTED: By well-established, 41-physician, multi-specialty group in Ohio. Major regional medical center including four rheumatologists. Should be board certified or eligible. Please enclose current curriculum vitae with reply to Box 824 c/o Ohio State Medical Journal.

FAMILY PRACTICE: Partners need associate in busy practice in fast-growing community. Southwest Ohio near city hospitals and medical schools. Write or call collect: G. K. Ohlhauser, M.D., 309 Reading Road, Mason, Ohio 45040, phone 513/398-6010.

EXCELLENT FEE-FOR-SERVICE INCOME: Athens, Ohio. Salary $50,000-$70,000 per year plus. Rapidly expanding emergency department with growth potential. Flexible scheduling. Outstanding university town, home of Ohio University, located in the rolling foothills of southern Ohio. Send curriculum vitae to Eric Jenison, M.D., Director of Emergency Services, O'Bleness Memorial Hospital, Athens, Ohio 45701, or call Toll Free 800/325-3982, Ext. 220.

GENERAL MEDICAL OFFICES AVAILABLE FOR RENT: In Hartville, reportedly the fastest growing township in Ohio. New construction permitting individual furnishing. Physically attached to Cancer Center with diagnostic x-ray, laboratory, and pharmacy facilities. Contact George N. Swallon Agency, Canton, Ohio, 216/456-3495, or inquire of R. K. Loeffler, M.D., 650 South Prospect, Hartville, Ohio 44632.

FOR SALE: Log cabin, built on six acres of wooded ground, four miles north of Tappan Lake and three miles south of Scio, Ohio. Approx. 1,000 ft. off State Rt. 646. 2½ hour drive from Columbus or Cleveland. The logs are over 100 years old and are in good, sound condition. Main cabin is 16′ x 22′ with bedroom and bath built on one side (12′ x 14′). Electric baseboard heaters and large fieldstone fireplace. Loft on one end of main cabin, which can be used for bedroom. Approved septic system and good water supply. For additional information, write: Cabin, Box 552, Scio, Ohio 43988, phone: 614/945-7111. Price: $65,000.

MARION, OHIO: Excellent opportunities in Central Ohio. Existing and new, solo, partnerships, or association practices available and seeking physician support. Top compensation— reliable cross coverage. Exceptionally attractive, 250-bed, well-equipped regional medical center hospital within walking distance from offices. Industry and agriculture support city/45,000; county/65,000; and total trade area/250,000. Excellent schools and residential areas. Fifty-minute, easy drive to Columbus. Active need for—

FAMILY PRACTICE
INTERNAL MEDICINE
OTOLARYNGOLOGY
PEDIATRICS
ORTHOPEDIC SURGERY
EMERGENCY MEDICINE
GENERAL SURGERY

We are seeking either rural or city-oriented physicians. Send C.V. or contact— ROBERT FLINT, Marion General Hospital, MARION, OHIO 43302 — or call 614/382-8211 or 382-3442 any time.

INTERNIST WANTED: Need additional internal medicine physician. Board qualified. Established group practice in Lakewood, Ohio. Excellent salary. Fringe benefits with full membership in group within one year. Reply Box 815, c/o Ohio State Medical Journal.

WILDERNESS SITE FOR SALE: Secluded, recreational retreat. Heavily wooded 95 acres. Horse trails, fishing, excellent hunting— bird and game. Remote, but good roads. Ideal for lodge or camp-site for individual or group ownership. Near Hillsboro, 90 minutes from Dayton, Columbus, and Cincinnati. Write: Phil Dobert, M.D., 6296 State Road 753, Route 4, Hillsboro, Ohio 45133.

OBSTETRICIAN-GYNECOLOGIST WANTED: To join well-established corporation in Central-Northwestern Ohio city. First-year salary $40,000; with benefits $74,000. Early full membership in corporation. Partner of 25 years retiring. Contact Box 820 c/o Ohio State Medical Journal.

AVAILABLE: Long-established physician's office and examining rooms. Excellent practice opportunities for general practitioner or specialist in a growing community. Within 10 to 12 miles to three large hospitals in Warren, Ohio. Combination residence-office. Lease available for office and option to purchase entire. Reply to Louis E. Jerry, Realtor, P.O. Box 185, Newton Falls, Ohio 44444.

MEDICAL DIRECTOR AND STAFF PHYSICIANS: County-owned-and-operated, long-term facility with skilled nursing, tuberculosis, pediatric, chronic illness, alcoholism detox, and rehab divisions. Full-time positions available immediately in 199-bed, JCAH-approved facility. Ohio license required. Salary negotiable. For further information write to: Kathryn E. Shearer, Assistant Administrator, Molly Stark Hospital, Box 9122, Canton, Ohio 44711, phone: 216/875-5531.

FOR SALE OR LEASE: Large doctor's office, 5,000 sq. ft. X-ray equipment. 328 E. State Street, Columbus, Ohio, across from Grant Hospital. Phone: 614/258-5644.

JULY STAFF EMERGENCY DEPARTMENT OPENING: Zanesville, Ohio. A 500-bed modern hospital with excellent backup. Flexible scheduling. Minimum guarantee/fee-for-service income $50,000-$70,000. Only 50 miles from Ohio State University, great recreational area. Send curriculum vitae to Howard Marsh, M.D., Director of Emergency Services, Good Samaritan Medical Center, 800 Forest Avenue, Zanesville, Ohio 43701, or call Toll Free 800/325-3982, Ext. 220.

GENERAL PRACTITIONER WANTED: To join multispecialty group practice in Northeastern Ohio. Present group consists of two surgeons, two internists, and two general practitioners. General practice limited primarily to adult medicine. No surgery or obstetrics required. For further information call collect or write: Glenn E. Eippert, M.D., or Richard S. Millberg, M.D., 430 West 25th St., Ashtabula, Ohio 44004. Phone: 216/998-1212.

SEEKING: Two general physicians, internists. Established practice in North-Central Ohio. Modern professional building. Corporate advantages. Reply Box 822 c/o Ohio State Medical Journal.

FAMILY PRACTICE — RURAL PRACTICE: Northwest/central rural/agrarian community of 1200/1500 needs family practice physician. Practice could expand to cover 3000/3500 population area. No physician now practicing. Community will support. Major regional hospital within driving distance. Contact ROBERT FLINT, MARION GENERAL HOSPITAL, MARION, OHIO 43302, phone 614/382-8211 or 382-3442.

HOUSE PHYSICIANS WANTED: For a community hospital located in northeast Ohio. Housing and uniform allowances provided. Attractive fringe benefits, including insurance. Salary negotiable. Must have current Ohio licensure. Reply Box 813 c/o Ohio State Medical Journal.

MAY 1978
Volume 74, Number 5

THE OHIO STATE Medical Journal

ABSTRACT

OF THE

PROCEEDINGS OF THE OHIO STATE MEDICAL SOCIETY

LIBRARY
UC SAN FRANCISCO
MAY 30 1978

In the years 1846, 1847, and 1848.

NEIL HOUSE, COLUMBUS, OHIO,
Thursday Evening, May 14th, 1846.

A number of medical gentlemen assembled, and organized a meeting, by the selection of G. W. BŒRSTLER, Chairman, and JAS. F. HIBBERD, Secretary.

The chairman stated the object of the meeting, whereupon a constitution was reported and adopted, as the temporary basis of The Ohio State Medical Society.

Dr. BAKER moved that a central Board of seven censors be appointed by the chairman, to receive the names of applicants and decide upon their qualifications for membership.

DRS. F. CARTER, J. P. KIRTLAND, J. W. BIGELOW, J. F. HIBBERD, E. H. DAVIS, J. J. MCILHENNY, and J. P. JUDKINS, were appointed said Board.

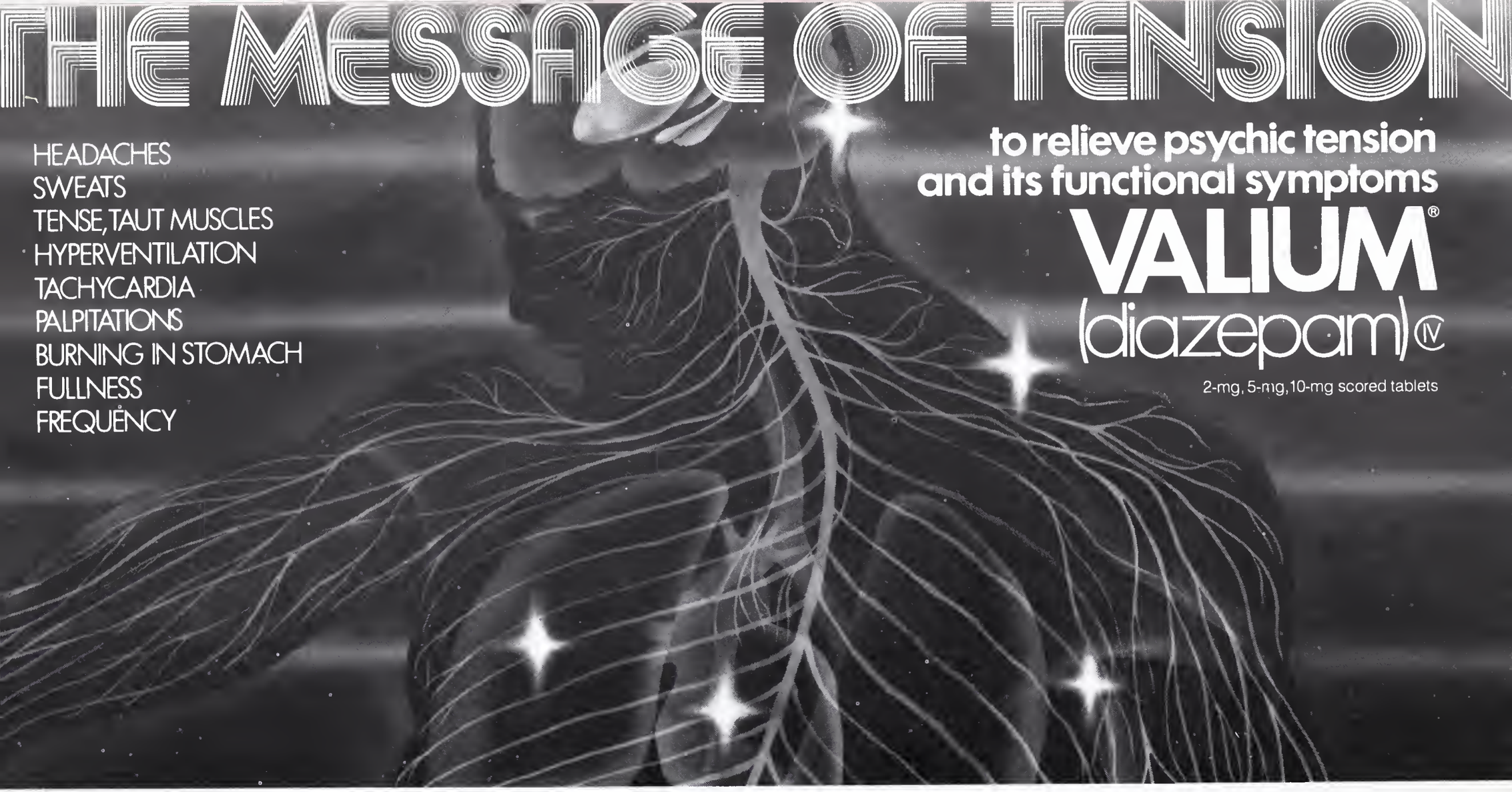
The Board reported the following named persons, who were then present, as qualified for membership:

Dr. G. W. BŒRSTLER,
Dr. WM. TREVITT,
Dr. GEO. J. SACHSE,
Dr. H. LATHROP,
Dr. D. A. COY,
Dr. R. THOMPSON,
Dr. JOHN BUTTERFIELD,
Dr. R. L. HOWARD,
Dr. A. H. BAKER,
Dr. SAM'L. ST. JOHN,
Dr. A. O. LINDSLEY,
Dr. A. W. THOMSON,
Dr. R. HILLS,
Dr. W. R. KABLE,
Dr. DAVID WILSON,
Dr. M. Z. KREIDER,
Dr. J. B. THOMPSON,
Dr. S. M. SMITH.

The Board of Censors then retiring, the qualifications of each were duly considered by the remainder, and they were severally admitted to membership—in all 25.

THE LIBRARY
ACQUISITIONS DIVISION
UNIVERSITY OF CALIFORNIA, SAN FRAN.
SAN FRANCISCO, CALIFORNIA 94143

PUBLISHED BY THE OHIO S... ASSOCIATION



VALIUM®(diazepam)

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome, convulsive disorders (not for sole therapy).
The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Legislative Update

the state scene

(Courtesy the OSMA Department of State Legislation)

Committee Rejects Optometrists' Bid to Administer Diagnostic Drugs

The efforts of the Ohio State Medical Association and the Ohio Ophthalmological Society have paid off with the House Judiciary Committee's rejection of a motion to recommend SB 163 (Jackson, D-Cleveland). This bill would permit optometrists (nonmedically trained practitioners) to administer "diagnostic drugs." Although the motion was defeated, SB 163 can be reconsidered by the Committee at anytime, making continual physician contacts with their local representatives of the utmost importance.

The Committee's negative vote on SB 163 stops the movement of the Ohio Optometric Association's proposal. Rep. Harry Lehman, Chairman of the House Judiciary Committee, has directed the OSMA, the Ohio Ophthalmological Society, and the Ohio Optometric Association to meet to identify the problems with SB 163 and to work toward a resolution of the differences. Such meetings are being held presently.

During debate, the Committee accepted three amendments offered by Rep. Richard Finan (R-Cincinnati). These amendments increased the bill's educational requirements and attempted to begin limitation of the drugs requested. Although Rep. Finan originally attempted to amend the bill to require an additional year of training to be prescribed by the State Medical Board, the amendment was altered to require a minimum of 12 semester hours of study (prescribed by the State Medical Board) prior to granting a license to use dangerous drugs. Rep. Finan also successfully sponsored an amendment to require that continuing education be prescribed by the Medical Board.

Although SB 163 does not define the nebulous term *diagnostic pharmaceutical agents,* Rep. Finan again successfully amended the bill to be slightly more specific in reference to general categories of drugs that optometrists are requesting permission to administer.

Despite these amendments, a majority of the Judiciary Committee felt SB 163 should not be recommended for passage by the full House. Again, SB 163 is not a dead issue even though the motion for recommendation was defeated. The most important factor was, and continues to be, the individual physician contacts with local legislators. All local legislators should be contacted and apprised of the Judiciary Committee's vote against the recommendation of SB 163 and to explain the hazards involved when nonmedically trained practitioners administer dangerous drugs.

The OSMA members and the staff of the OSMA Department of State Legislation were congratulated by members of the Judiciary Committee for their professionalism in presenting the arguments against SB 163. Physicians should contact members of the House Judiciary Committee and thank them (regardless of their affirmative or negative vote) for their excellent deliberations on this issue and their efforts to concentrate on the facts rather than the emotions of the issue. Also, physicians should offer assistance in helping the legislators to better understand SB 163 and its implications. Continued dialogue between physicians and legislators is essential if physicians expect the General Assembly to understand medical issues.

Update on Certificate of Need

On April 13th, Blue Cross testified in favor of Sub. SB 349 (Valiquette, D-Toledo) provided certain exemptions are granted to their health maintenance organizations (HMOs). However, almost in the same breath, the representative of Blue Cross argued against exempting physicians' offices from the certificate-of-need bill. He argued that Blue Cross HMOs need special protection, but that physicians would increase the total cost of health care by purchasing duplicate-and-unnecessary, expensive equipment. Blue Cross also argued that they should be permitted to "help" and to participate in the review process beyond the local level.

The subcommittee began hearing opposition testimony to SB 349 on April 20th, when Richard Ruppert, M.D., President, Medical College of Ohio at Toledo, presented testimony before the House subcommittee. Dr. Ruppert requested that an exemption for all free-standing ambulatory facilities and physicians' offices be included in SB 349.

Rep. Larry Christman (D-Englewood), chairman of the subcommittee, discussed the issue of duplication of expensive medical equipment. Dr. Ruppert spoke in detail about the CAT-scanner issue. He effectively refuted the argument that the CAT scanner is an "expensive toy" by showing that it is a valuable piece of equipment that reduces morbidity and mortality in diagnostic procedures. He called it a "breakthrough in new diagnostic equipment."

The subcommittee was made aware that it would be possible for a physician or hospital to purchase a number of smaller pieces of equipment (costing under $100,000 per piece) to reach the same capacity of service of a major piece of equipment costing over $100,000 or $150,000. Dr. Ruppert explained that a single piece of equipment would be far more economical and would reduce the cost of health care. He said that it is important for health planners to realize that just because a piece of

equipment is expensive, it is by no means inappropriate or unnecessary.

Representing the Medical College of Ohio, Dr. Ruppert discussed the necessity of distinguishing between state institutions that are funded directly from the General Assembly and health systems agencies (HSAs) which encompass regional areas. The legislators agreed that the unique relationship between these two entities needed further investigation.

Richard Klecker, M.D., a member of the Mid-Ohio Health Planning Executive Board and a radiologist in private practice in Columbus, testified for himself to the problems of private and independent radiologists. The certificate-of-need bill would be a stumbling block for such practitioners when trying to update and to maintain the high quality delivery of medical care due to the $100,000 or $150,000 equipment purchase restriction. Dr. Klecker told the subcommittee that CAT scanners are available for less than $100,000, but they are far less cost efficient than the more expensive equipment.

Other opposition testimony has come from hospital administrators, the Ohio Department of Mental Health and Retardation, and representatives of the Kaiser Community Health Foundation (an HMO). The subcommittee will continue its deliberations on SB 349 during the coming weeks.

Most of the subcommittee members seem to believe that physicians' offices should be exempted, but they are still uncomfortable exempting equipment purchases in excess of $100,000 to $150,000. Blue Cross has yet to present the memorandum showing the millions of dollars of equipment that exists in the cost range of $100,000 to $150,000. The OSMA position on SB 349 continues to call for exemption of physicians' offices and "free-standing ambulatory care facilities" from all requirements of the certificate-of-need law.

Third-Party Payor Asks Immunity From Civil Liability

The House Insurance, Utilities, and Financial Institutions Committee held its first hearing on SB 314 (Butts, D-Cleveland). The sponsor of the bill, Sen. Charles Butts, and legal counsel for Medical Mutual of Cleveland presented testimony. SB 314, which passed the Senate in March, grants immunity from civil liability to third-party payors and their employees when investigating the propriety of a provider's medical claim.

The bill was amended successfully in the Senate by Sen. Michael Schwarzwalder (D-Columbus) to define malice and to limit the immunity to investigations conducted without malice. Originally, SB 314 had granted unlimited immunity to third-party payors, leaving physicians no recourse against the third-party payor for negligence in the preparation of "cost control communications or investigations."

Sen. Butts told the Committee that the purpose of SB 314 is to reduce health-care costs by facilitating the investigation and reporting of abuses committed by physicians. He cited the results of the Cuyahoga County Grand Jury (Skylar Report) as an example of excessive physician billing to third-party payors. Although Sen. Butts opposed the reduction of the immunity provision in the amended bill both in the Senate Judiciary Committee and on the Senate floor, he told the Committee the Senate obviously believed some limitation on immunity was needed to protect the rights of the physician.

Testifying in support of SB 314, a representative from Medical Mutual cited a few dramatic examples of overbilling by physicians. He stated that Medical Mutual needs a mechanism to enable them to investigate physicians suspected of fraud without the threat of a lawsuit by the physician. The company claimed it was afraid to turn the information collected on fradulent billing over to peer review committees or the State Medical Board.

One legislator called SB 314 a license for third-party payors to go on "fishing expeditions." The OSMA continues to oppose SB 314 as unnecessary.

Bill Would Allow Emergency Medical Technicians to Administer Intravenous Lifelines

The Ohio House of Representatives twice approved and sent to the Senate HB 1092 (Branstool, D-Utica). This bill permits emergency medical technicians-ambulance (EMT-As) to maintain "intravenous lifelines" for emergency treatment. HB 1092 is a legislative response to an opinion by the Ohio Attorney General that current law does not permit EMT-As to administer IVs.

The House originally passed HB 1092 by a vote of 91 to one, but no hearings were held by Senator Morris Jackson's Education and Health Committee during the last few weeks of the session. In an effort to expedite this needed legislation, Rep. Branstool amended HB 1092 into another EMT-A bill, SB 347 (Nabakowski, D-Lorain). The House approved the amendment and SB 347, but the Senate failed to concur in the House amendments. The bill will be heard in a conference committee.

Rep. Branstool worked closely with the OSMA in resolving the OSMA's concerns. Rep. Branstool and Rep. Richard Finan (R-Cincinnati) should be commended for effectively carrying the bill to the floor. Sen. Nabakowski, who recognized the need for HB 1092, also should be commended for agreeing to amend SB 347.

Turn to page 320 for pictures of the 1978 OSMA Auxiliary "Day at the Legislature"

OSMA OFFICERS
President
WILLIAM M. WELLS, M.D.
241 Hudson Avenue
Newark 43055
President-Elect
JOHN J. GAUGHAN, M.D.
7911 Detroit Avenue
Cleveland 44102
Past President
GEORGE N. BATES, M.D.
2102 Shenandoah Road
Toledo 43607
Secretary-Treasurer
ROBERT G. THOMAS, M.D.
630 East River Street
Elyria 44035

EDITORIAL STAFF
Consulting Medical Editor
RICHARD L. MEILING, M.D.
Managing Editor and Business Mgr.
HART F. PAGE
Executive Editor and Executive Business Manager
LINDA A. PORTERFIELD
Editorial Assistant
MARY LOU BRADY
Communications Editor
REBECCA J. DOLL
Continuing Medical Education Editor
GAIL E. DODSON
Ass't. Continuing Medical Education Editor
DAVID C. TORRENS
Federal Legislation Editor
CHARLES W. EDGAR
Field Service Editor
ROBERT E. HOLCOMB
Government Relations Editor
HERBERT E. GILLEN
Health Education Editor
ROBERT D. CLINGER
Membership Editor
KATHERINE E. WISSE
Organization Services Editor
JERRY J. CAMPBELL
State Legislation Editor
D. BRENT MULGREW, ESQ.
Ass't. State Legislation Editor
RICHARD A. AYISH

Address All Correspondence, Address Change, & Reprint Request (unless otherwise, noted):
Executive Editor
The Ohio State Medical Journal
600 South High Street
Columbus, Ohio 43215
Phone: 614/228-6971

Published monthly under the direction of The Council for and by members of The Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215, a scientific society, nonprofit organization, with a definite membership for scientific and educational purposes.

1977 Subscription: $10 per year, single copy $1.50 (outside U.S. $13 and $2).

Entered as second class matter July 5, 1905, at the Post Office at Athens, Ohio, under the Act of Congress of March 3, 1879. Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918. Second-Class Postage Paid at Athens, Ohio.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertisers must conform to policies and regulations established by The Council of the Ohio State Medical Association.

Publication office: 900 East State Street, Athens, Ohio 45701.

Printed by
The Lawhead Press, Inc., Athens, Ohio

VOL. 74 MAY 1978 NO. 5

OHIO STATE Medical Journal

Clinical and Scientific Articles

ESTIMATING FETAL LUNG MATURITY. A COMPARISON OF L/S RATIO, FOAM STABILITY, AND FETOGRAM 287
Thomas L. Gross, M.D., Cleveland, and William M. Cook, M.D., Akron

ELEVATION OF SERUM URIC ACID LEVELS IN PATIENTS WITH SEIZURES 292
George W. Paulson, M.D., Columbus

MATERNAL HEALTH IN OHIO: MATERNAL MORTALITY REPORT FOR OHIO — 1974 294
By the OSMA Committee on Maternal and Neonatal Health

PREPARING THE RESIDENT FOR CONTINUING MEDICAL EDUCATION 296
Stephen F. Pariser, M.D., Columbus; Bruce A. Jones, M.D., Columbus; and Rudolf Kaelbling, M.D. (deceased)

INTOXICATION BY DATURA STRAMONIUM 300
Ivan A. Lopez, M.D., Massillon

CANCER EDUCATION SERIES: SUPPORT OF THE CANCER PATIENT AND HIS OR HER FAMILY 304
Thomas P. Bowlus, Toledo

Special Articles

GEORGE W. BOERSTLER, M.B. (1792-1871) FIRST PRESIDENT OF THE OHIO STATE MEDICAL SOCIETY (ASSOCIATION) 308
Chester P. Swett, M.D., Lancaster

REMARKS TO SHAREHOLDERS
Physicians Insurance Company of Ohio Annual Meeting 310
George N. Bates, M.D., Toledo

OHIO MEDICAL INDEMNITY MEDICAL NECESSITY PROGRAM 316
D. Tom Dwyer, Columbus

OSMA AUXILIARY "DAY AT THE LEGISLATURE" 320
Linda A. Porterfield, Columbus

Features

Legislative Update — State....281
Letters to the Editor.....284
Obituaries.....302
Continuing Education Programs..315
Journal Advertisers.....315
Proceedings of the Council.....322
News.....333
Medical School Highlights.....337
New Members.....339
Colleagues in the News.....340
OSMA Placement Service Ads....342
Classified Ads.....345

COVER: The Ohio State Medical Society (Association) was formed the evening of May 14, 1846. Twenty-five physicians comprised the early membership of our organization whose number now exceeds 11,000. Dr. George Boerstler served as the first president of the Association. (See article this issue.)

THE OHIO STATE Medical Association

Letters to the Editor

Dear Sir:

Stoll, Hughes and Kim recently reviewed Kaposi's sarcoma, including six recent cases in Ohio.* Their emphasis on the rarity of this entity prompted our review of the cases in the Armed Forces Central Medical Registry's Registry of Tumors. These cases are drawn from a population consisting of any patient diagnosed or treated for cancer in any US military hospital, worldwide, with attempted lifetime follow-up. This series has the advantage of representing the total spectrum rather than individual case reports which may tend to emphasize the more spectacular cases.

There are 24 cases of Kaposi's sarcoma in the Registry at the present time. Nineteen patients were male and five female. All but one were Caucasian. The other was "negroid." The age at the time of diagnosis ranged from one nine-year-old boy to five patients over 74 years of age. The mean age of the patients was 51.46 years, with a standard deviation of 19.12 years. The year of diagnosis ranged from 1962 to 1977. At the time of diagnosis, there was no evidence of metastases in any, and lymph nodes were clinically negative in all. The most common site was the lower extremity (19 cases); three involved the upper extremity, one was on the face, and one was multicentric when first seen. In all instances the diagnosis was on the basis of tissue examination. All had surgical excision of at least the initial lesion, and seven also had radiation therapy.

Five patients had other primaries. These were: squamous cell carcinoma of the eyelid, carcinoma of the breast, carcinoma of the rectum, multiple myeloma, and basal cell carcinoma of the face.

Seven patients have been followed less than one year, so their current status is unknown. Two patients have been free of recurrences for two years, two for three years, and two for four years. Four patients have remained free of recurrences for six years or longer, the longest of these being one who remained recurrence-free for 11 years. Four patients followed for longer than one year had recurrences which were treated and the patients subsequently followed for at least two years without evidence of recurrence.

Eight of these patients had known hypertensive cardiovascular disease indicated on their records. An additional two patients might have had some cardiovascular problem in that one was an obese woman with "two pillow orthopnea," and the other had an elevated blood pressure recorded without further comment in the record.

One patient had a clinical diagnosis of a "small intracranial hemorrhage," etiology unknown, with subsequent recovery. In eight there was inadequate medical data furnished to determine whether there was also a cardiovascular problem and in two cases, the records, as sent, stated or implied that the patient had no evidence of cardiovascular disease.

Three of the five patients who died were autopsied. One patient died of cirrhosis of the liver, another of intracerebral hemorrhage associated with hypertension. The third of the group autopsied, the patient with the diffuse Kaposi's lesions, died two years after the diagnosis of the Kaposi's sarcoma was made. He had been treated for hypertension and congestive failure since his first myocardial infarction five years before the diagnosis of Kaposi's sarcoma. At autopsy, diffuse Kaposi-sarcoma lesions were found, including the lung, liver, and spleen. The cause of death was cardiac failure with severe hypertension and cardiomegaly. At the time of his death, the question was raised whether the multiple shunt-effect of the diffuse Kaposi lesions might have been contributory to his cardiovascular problem.

Two other patients who died were not autopsied. One had "cerebral thrombosis" as the clinical cause of death, and no record is available for the circumstances of the death of the other.

In conclusion, with the exception of the one patient dying with diffuse systemic involvement, all of the other patients appeared to do well with local excision of the lesions, with or without radiation therapy. The lesions tended to recur, but were easily removed at the time. After several recurrences initially, the patient in several instances has remained lesion free for several years.

This is a small series, not yet completely studied, but these cases are mentioned at this time because the Armed Forces Medical Registry, with its subregistry, the Armed Forces Registry of Tumors, is being closed. All of the microfilmed case records and computer tapes will be sent to the Armed Forces Institute of Pathology in Washington, D.C.

/s/Janice A. Mendelson, M.D.
Colonel, MC, USA
Director
Armed Forces Central Medical Registry
Brooks Air Force Base, Texas 78235

*Stoll DB, Hughes JH, Kim K: Kaposi's Sarcoma: A Clinical Study in Ohio. *Ohio State Med J* **73**:813-817, Dec. 1977.

To the Editor:

Colonel Mendelson's contribution of data and observations regarding Kaposi's Sarcoma is greatly appreciated. Not only is the clinical information of significant value, but also the information lends added support to our feeling that new clues related to the basic neoplastic process may be found by further study of this tumor. The high incidence of patients with a second primary neoplasm suggests that an immunological deficiency may exist in this disease. The pattern of the disease in Africa has suggested a possible viral factor in the etiology of this tumor in that continent. The morphology of the tumor suggests that the angiogenic factor discussed by M. Judah Folkman may be involved in the tumor growth.

While the Epidemiology Branch of the National Cancer Institute provided a great contribution through the *Atlas of Cancer Mortality for U.S. Countries: 1950-1969,* it may be that application of such epidemiologic methodology to less common neoplasms such as this in the United States could be of similar significant value. Further efforts in these areas certainly appear justified.

Should a citation of reference be in order, the authors of the *Atlas of Cancer Mortality for U.S. Counties: 1950-1969* is Department of Health Education and Welfare Publication (NIH) 75-780 by Mason, TJ, McKay, FW, Hoover, R., Blot, WJ and Fraumeni, J.F.

/s/John H. Hughes, M.D.
Director Emergency Services
University of Arizona
Health Sciences Center
Tucson, Arizona 85724

To the Editor:

I enjoyed the October issue* of *The Ohio State Medical Journal.* The quality of this *Journal* has steadily improved in the past couple of years.

I think that the continuing medical education examination is an interesting experiment for this *Journal.* As you know, a number of throw-away journals have tried this and I have no idea how successful they were. I would certainly appreciate some feedback information as to how many people might have participated in this Category I Continuing Medical Education. Keep up the good work.

/s/Manuel Tzagournis, M.D.
Associate Dean
The Ohio State University
College of Medicine

*Volume 73, Number 10

When was the last time your practice gave you a good night's sleep?

We're not talking about sleep that comes from sheer exhaustion.

We're talking about the kind of sleep that comes from knowing you practiced medicine today the way it was meant to be practiced. Of giving your patients the very best in medical care. With no compromises.

And a sleep that comes from knowing you won't be spending all of tomorrow morning filling out Medicare insurance forms, or attending to a myriad of other time-consuming, nonmedical duties.

But there is a practice that offers an alternative to the kind of medicine you're now practicing. A practice in the U.S. Navy.

The Navy physician.

As a Navy physician, we feel your time is too valuable to spend on administrative details. So they're kept to a minimum. Instead, a highly trained staff of professionals attends to the paperwork. The end result is that almost all your time can be spent practicing medicine.

A challenging practice.

You'll be given a practice that's as varied and challenging as any you'll find in a civilian setting. You'll be treating active duty personnel as well as their dependents and retired personnel.

Insurance.

A recent Act of Congress now makes it unnecessary for federally employed physicians to carry high cost insurance. As a practicing Navy physician, you will receive professional liability protection under the Federal Tort Claims Act.

Other benefits.

There are plenty of other great benefits that go with being a Navy physician. Good pay— $30,000 to start, more, depending on your experience. A family life with time for your family. Associating with other highly motivated physicians. Even 30 days' paid vacation a year.

But the best way to get all the facts is to mail the coupon, or call the Medical Recruiter, toll-free, 1-800-282-1288.

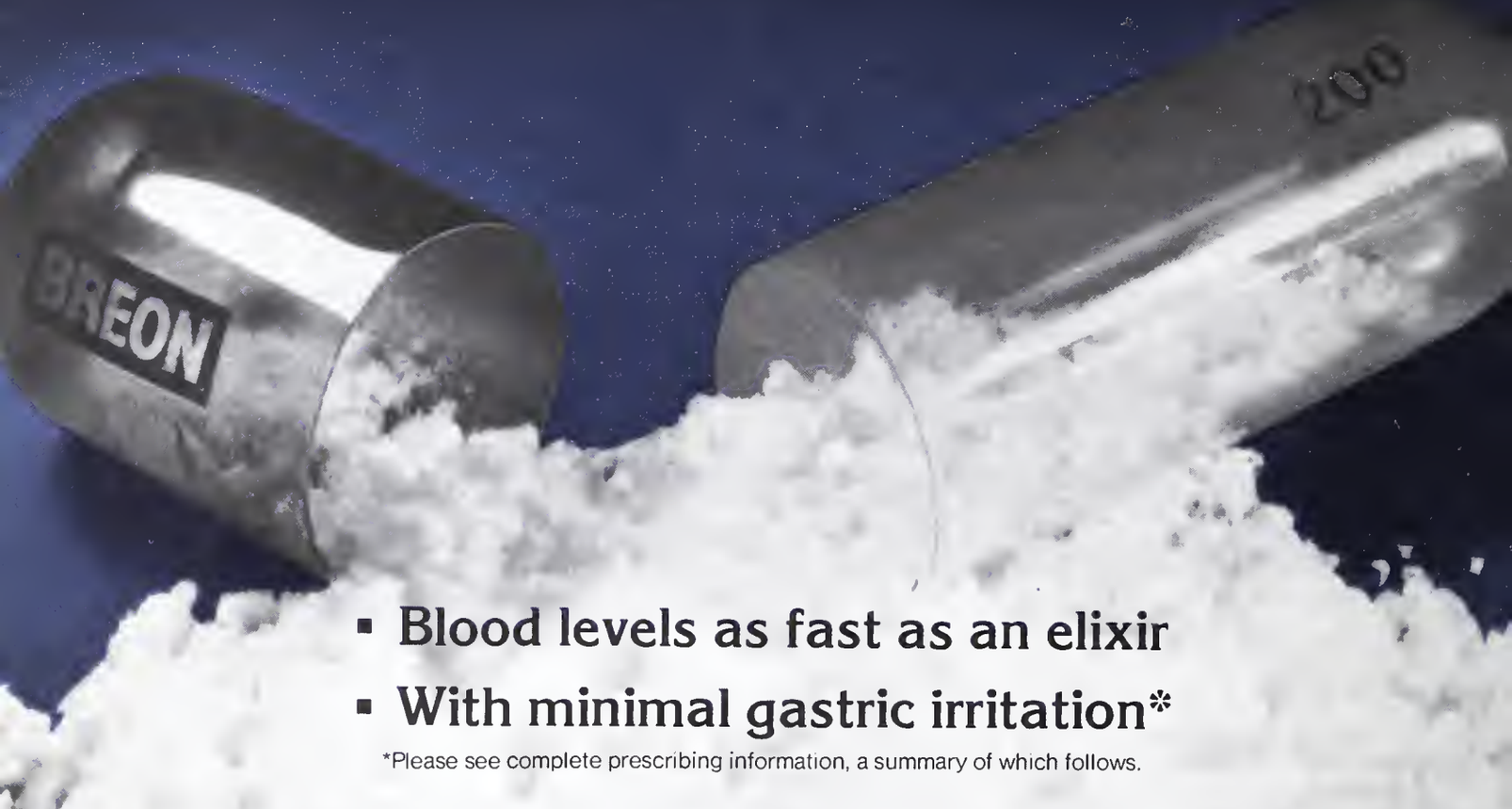
Be the doctor you want to be. In the Navy.

A Difference in Theophylline Therapy

micro-pulverized

BRONKODYL® Capsules

brand of theophylline, USP anhydrous



- **Blood levels as fast as an elixir**
- **With minimal gastric irritation***

*Please see complete prescribing information, a summary of which follows.

DESCRIPTION:
Each green and white hard gelatin capsule contains theophylline USP anhydrous, 200 mg., in a micro-pulverized form. Each brown and white hard gelatin capsule contains 100 mg. The elixir contains 80 mg. theophylline per 15 ml. in a 20% alcohol elixir (approximately 20 calories, 0.9 gm carbohydrate per tablespoonful).

ACTION: Theophylline is a methylxanthine which relaxes the smooth musculature of the bronchioles through its inhibition of the conversion of cyclic adenosine monophosphate to adenosine monophosphate by phosphodiesterase. It also has diuretic, cardiotonic, and CNS stimulant effects.

INDICATIONS: Bronkodyl is indicated for symptomatic relaxation of bronchiolar spasm in the chronic obstructive bronchopulmonary diseases; e.g., bronchial asthma, chronic bronchitis and pulmonary emphysema.

CONTRAINDICATIONS: Bronkodyl is contraindicated in persons known to have had serious idiosyncratic responses to theophylline, its salts, or the other methylxanthines, theobromine, or caffeine and may be contraindicated in peptic ulcer.

WARNINGS: All methylxanthines should be used with caution in children and in others who are currently taking bronchodilator products, especially in rectal dosage form, which may contain theophylline or related drugs.

USAGE IN PREGNANCY: Although theophylline has been used for many years, with no evidence of adverse fetal effect or teratogenicity, its safety in pregnancy has not been established. Therefore use of Bronkodyl during lactation or in women of childbearing potential requires that possible benefits of the drug be weighed against possible hazards to fetus or child.

PRECAUTIONS: Bronkodyl should be used with caution in patients with cardiac or circulatory disease.

ADVERSE REACTIONS: Gastrointestinal: Epigastric distress, nausea, vomiting. Cardiovascular: palpitations. CNS: Insomnia, restlessness, irritability, convulsion.

DOSAGE AND ADMINISTRATION: Adults: Usual dosage of Bronkodyl is 200 mg. every 6 hours (four doses in each 24 hours). This dosage may be adjusted to reflect individual clinical response as an indication of slow or rapid metabolism of the drug. If adverse reactions are encountered, each dose may be reduced, or the interval between doses may be lengthened, or both. If clinical response is not satisfactory, indicating possible rapid inactivation of the drug, dosage may be gradually increased to achieve the desired response. In some instances of either too slow or too rapid metabolism, plasma levels of theophylline should be determined and dosage adjusted accordingly to achieve levels above 10 mcg/ml, but not to exceed 20 mcg/ml.

Dosage in Children: Usual dosage should be based on administration of 10 mg per kg per 24 hours, divided in 4 doses per day, given every 6 hours. As this may not be possible with use of the capsules, Bronkodyl elixir may be used. Theophylline saliva levels (approximately 60% of simultaneous blood levels), may facilitate dosage adjustments, especially in children, to obtain appropriate response.

HOW SUPPLIED:
Bronkodyl 100 mg., brown and white capsules in 100's, Code #1831.
Bronkodyl 200 mg., green and white capsules in 100's, Code #1833.
Bronkodyl Elixir, 80 mg. per 15 ml, in pints, Code #1835.

BREON LABORATORIES INC.
90 Park Avenue, New York, N.Y. 10016

THE OHIO STATE Medical Association Clinical and Scientific

Estimating Fetal Lung Maturity

A Comparison of L/S Ratio, Foam Stability Test, and Fetogram

Thomas L. Gross, M.D.
William M. Cook, M.D.

The correlation of fetal lung maturity with the results of amniotic fluid analysis was studied in 81 samples obtained over a one-year interval. Lecithin/sphingomyelin (L/S) ratios were compared to the foam stability test (FST), amniotic fluid creatinine, and raentgenagrams for fetal age. Both the L/S ratio and FST were reliable for predicting fetal lung maturity. The L/S ratio and FST used alone were unreliable in predicting fetal lung immaturity (72 percent false negatives). The L/S ratio detects some false-negative FSTs; and the FST detects same false-negative L/S ratios. In high-risk patients, we feel both tests should be used.

IN OUR SOCIETY TODAY, hyaline membrane disease (HMD), or the idiopathic respiratory distress syndrome (RDS), is the major cause of death during the first week of life.[1,2] A great deal of interest has been expressed in determination of the lecithin/sphingomyelin (L/S) ratio and the foam stability test (FST) of the amniotic fluid as a means of assessing fetal lung maturity. Many reports, however, have noted discrepancies between the results of the L/S and FST in evaluating the clinical status of the infant.[3-7]

Gluck, when first reporting on the L/S ratio, noted it to be very accurate in predicting both the mature and immature fetus.[8] He stated that every L/S ratio less than 2.0 was associated with some degree of RDS.[9] Many authors have confirmed that the L/S ratio greater than 2.0 rarely is falsely positive.[10-12] False positives, when they do occur, are often associated with maternal diabetes[31] or fetal hypoxia.[14-15] Harvey, in a review of 45 articles, reports a false-positive rate of 2.2 percent.[16]

The correlation of the L/S ratio with immaturity has been markedly different, however. No large study has confirmed the accuracy of the immature L/S ratio first noted by Gluck.[9] One of the most accurate series diagnosing pulmonary immaturity was reported by Donald, in which there was a 63-percent incidence of RDS if the ratio was less than 2.0.[15] Others have shown a varying incidence of RDS from 12 percent to 80 percent when the L/S ratio was less than 2.0.[4,11,12,17-20] Most authors report that the majority of false-negative results occur in the range of 1.5 to 2.0 — "the transitional zone." However, Roux confirmed his technique by sending samples to Dr. Gluck's laboratory for comparison and then reported that, with an L/S ratio of less than 1.5, the incidence of RDS was 20 percent and HMD 5 percent.[21] Hobbins observed only a 25-percent incidence of RDS with an L/S ratio less than 1.0.[22] Harvey reviewed 25 series reporting L/S ratios less than 1.5, wherein 73 percent of infants developed RDS and 14 percent died.[16] Apparently, the chance of an infant developing RDS is quite high if the L/S ratio is less than 2.0, but no one has found it as accurate as Gluck.[9]

Foam Stability Test (FST)

The FST is based on the theory that surfactant can stabilize surface bubbles for relatively long periods.[23] Motoyama first reported that lung fluids could stabilize bubbles on a glass slide, and he called this bubble sta-

A list of the references for this article may be obtained from Dr. Gross at Cleveland Metropolitan General Hospital, 3395 Scranton Road, Cleveland, Ohio 44109

From the Department of Obstetrics and Gynecology, Akron General Medical Center, Akron, Ohio

Submitted July 20, 1977.

bility ratio.[24] Fozzard noted bubble stability in amniotic fluid to increase from early to late gestation.[25] It was left to Clements, however, to adopt this as a useful clinical test for fetal maturity.[23] This initial report by Clements reported no wrong predictions of maturity or immaturity. As with the L/S ratio, no series since then has shown these same results. The positive FST has been very accurate in predicting maturity. A summary of 11 articles reviewed by Harvey notes less than 1 percent RDS if the result of the FST is positive.[16] Notable exceptions are Thibeault, who reported an alarming 36 percent false positives,[26] and Olson, who found nearly 10 percent false positive.[3] Olson felt this was due to the use of a suboptimal end point.

Almost all authors now agree that the negative FST is poorly predictive of RDS. The false-negative rate varies from 31 percent to 91 percent.[4,6,27-29]

Variation in Technique

Numerous authors have reported slight variations in technique for the FST in attempting to decrease the incidence of false-negative results. These have included shaking the tubes longer, reading them sooner, and shaking them a second time.[20-30] Variations in reading the end point in order to decrease false negatives have been reported.[28,29,31]

Foam Stability Test Correlated with the L/S Ratio

Multiple authors have correlated the results of the L/S ratio with the FST. When including both positive and negative results for both tests, the correlation varies from 53 percent to 75 percent.[3,4,32] Broken down into positive and negative, Keniston found his immature FSTs were associated with 92 percent immature L/S ratios. However, his mature FSTs were associated with 63 percent mature L/S ratios.[4] Likewise, mature L/S ratios have been associated with 44 percent to 75 percent double-positive FSTs.[6,20,33] Boehm reported immature L/S ratios associated with immature FSTs 64 percent of the time.[5] Many of these articles assume the L/S ratio is the standard and use it to evaluate the results of the other tests.[33] However, this may not be acceptable as several authors have reported that the L/S ratio has more false negatives predicting pulmonary immaturity than the FST.[4,7] Moreover, the presence of a double-positive FST correctly predicting fetal maturity in the presence of an L/S ratio less than 1.5 has been reported.[5,34]

Materials and Methods

Amniotic fluid was obtained by transabdominal amniocentesis or by amniotomy at the time of delivery on 81 women with a variety of clinical problems (Table 1). Specimens containing blood or meconium were excluded from the study. The L/S ratio was determined and interpreted according to the technique of Borer, et al.[8] This technique was strictly adhered to, including incorporating 5 percent ammonium sulfate into the silica gel, a modification added later.[9] Prior to L/S determination, samples were centrifuged at 800 X gravity for three minutes, and the supernatant analyzed immediately. The FST was performed on fresh amniotic fluid prior to centrifugation, according to the method of Clements with the exception that only a 1:1 and 1:2 dilution were used.

Amniotic fluid creatinine value was determined by the Jaffe reaction on the SMA 12 autoanalyzer. The sample is centrifuged prior to analysis.

Thirty-five patients had x-ray films ordered by their attending physician to evaluate fetal maturity or the maternal pelvis within 72 hours of an L/S ratio. All x-ray films were examined retrospectively by one radiologist who did not know the results of the maturity studies. A mature fetogram was defined as one with a visible, distal femoral epiphysis (DFE). Excluded were roentgenograms of poor quality or those in which maternal bowel gas or bone made fetal ossification centers difficult to visualize.

Gestational ages of newborn infants were estimated by combining uterine size in the first trimester and appearance of unamplified fetal heart tones with menstrual data. This data was always correlated with a neonatal maturity assessment.[35]

The presence or absence of RDS was determined by clinical, roentgenographic, or radiologic findings. Neonates who died with roentgenographic or histologic evidence of HMD, or infants with RDS who required artificial ventilation, were considered to have severe RDS. All other neonatal respiratory distress was considered

Table 1. Clinical Problems Found in Study Patients

Type of Problem	No. of Patients
Rh sensitization	6
Chronic hypertension	3
Toxemia	15
Diabetes	
Class A	2
Class B-R	4
Miscellaneous:	
Placenta previa	2
Questionable dates	9
Prior cesarean section	22
Intrauterine growth retardation (IUGR)	2
Others:	
Maternal heart disease	1
Maternal renal transplant	1
Normal patients in labor	7
Total	74

Dr. Cook, Akron, Chairman, Department of Obstetrics and Gynecology, Akron General Medical Center; and Professor of Obstetrics and Gynecology, Northeastern Ohio Universities College of Medicine.

Dr. Gross, formerly of Akron, currently Fellow in Maternal and Fetal Medicine, Cleveland Metropolitan General Hospital, Cleveland, Ohio.

mild. Other disorders, such as pneumonia or transient tachypnea, are listed separately.

Results

The L/S ratio plotted against gestational age including normal pregnancies and those with maternal disease are shown in the Figure.

In correlating outcome of the L/S ratio and the FST with neonatal outcome, 44 patients were included. Only pregnancies in which the interval between amniocentesis and delivery was less than 72 hours were used. If either the L/S ratio was greater than 2.0 or if the FST was double positive, no RDS was seen.

An L/S ratio of 2.0 or greater was associated with a positive FST only 46 percent of the time.

Seven L/S ratios were less than 2.0 and two of seven babies developed RDS. Likewise, seven amniotic fluids had a negative FST and two of seven infants developed RDS. The false-negative rate with both the L/S and the FST was 72 percent. Eleven fluids had either a negative FST or immature L/S ratio (Table 2). In only one of 11 infants was the newborn lung maturity not predicted accurately when combining the L/S ratio with the FST.

Correlation of Amniotic Fluid Creatinine with L/S Ratio

Thirty-seven patients had an L/S ratio and a creatinine test performed on the amniotic fluid. Only mothers with a serum creatine value less than 0.9 mg per 100 ml and in which the fluid was obtained within 72 hours of delivery were used. Of 33 fluids with L/S ratios greater than 2.0, there were 28 with creatinine levels greater than 1.8 per 100 ml. Of four fluids with L/S ratios less than 2.0, three had creatinine values greater than 1.8 per 100 ml and resulted in infants with no HMD.

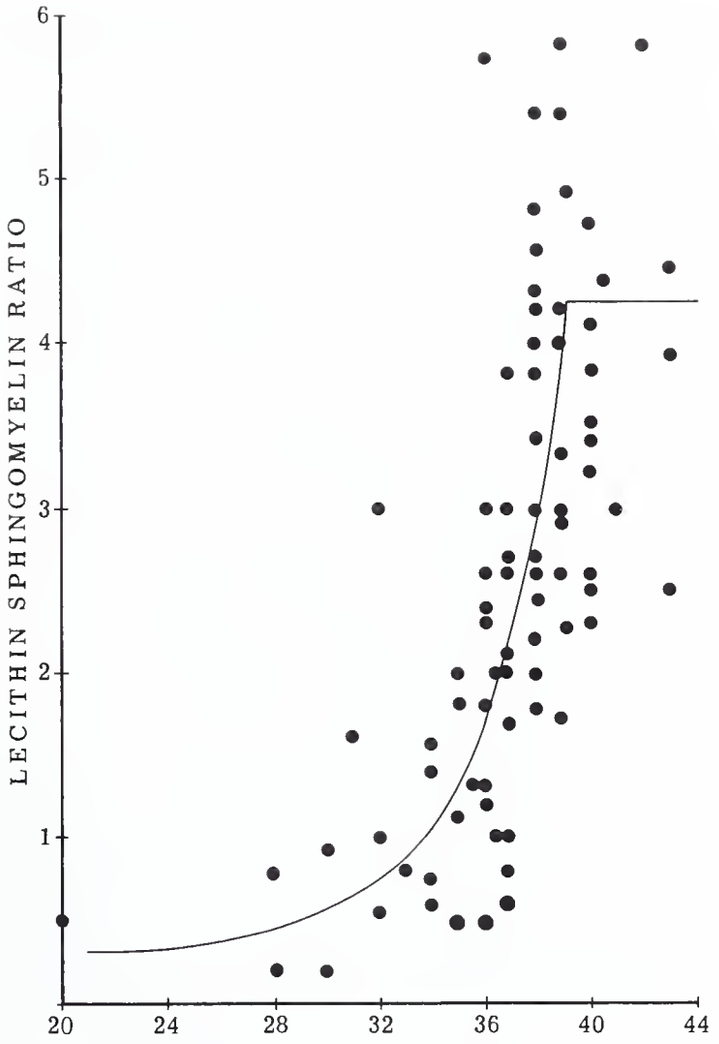
Correlation of the Fetogram and L/S Ratio for Fetal Maturity

A comparison of the results of the fetogram and L/S ratio is shown in Table 3. In our series, the presence of a DFE predicted the presence of a mature L/S ratio

Table 2. All Infants With L/S Ratio Less Than 2.0 or Negative FST Within 72 Hours of Delivery

Neonatal Outcome	FST	L/S
Died (RDS*)	—	0.8
Died (RDS)	—	1.6
Transient tachypnea	++	0.8
No RDS	++	1.3
No RDS	++	0.6
No RDS	++	0.6
No RDS	++	1.8
Transient tachypnea	—	3.0
No RDS	—	2.9
No RDS	—	2.0
No RDS	—	2.6

*Respiratory distress syndrome



L/S ratio by weeks of gestation in total population.

63 percent of the time. The lack of a DFE is specific for predicting an immature L/S 63 percent of time also.

Of the infants delivered within 72 hours of both studies, six had mature L/S ratios with no DFE and none developed RDS. Likewise, two infants with L/S ratios less than 2.0 but with DFE present developed no RDS.

Discussion

The results demonstrate that the amniotic fluid L/S ratio, FST, creatinine concentration, and fetogram are useful for predicting fetal maturity but with varying degrees of accuracy.

It has been reported from this hospital and others that an amniotic fluid creatinine level greater than 2.0

Table 3. Comparison of Amniotic Fluid L/S Ratio and Presence of Distal Femoral Epiphysis (DFE) in Patients Having Both Studies Within 72 Hours

L/S Ratio	Distal Femoral Epiphysis Absent	Distal Femoral Epiphysis Present
< 2.0	5/8 (63%)	3/8 (37%)
> 2.0	5/16 (37%)	10/16 (63%)

mg per 100 ml is associated with a mature fetus.[36] This test actually is dependent on fetal renal development and muscle mass.[3] Of 33 patients with a mature L/S ratio, 28 had creatinine levels greater than 1.8 mg per 100 ml. The creatinine level is helpful to use in conjunction with other studies, but the incidence of false negatives is too high to use alone.

Assessment of fetal bone maturity by x-ray visualization of fetal ossification centers has been done since the 19th century.[37] Spellacy is the only previous author to compare the presence of DFE with the L/S ratio in a large series of patients.[37] The results of our small series confirm his results: 37 percent of infants with mature lungs might be considered undeliverable if only the fetogram were used. In dealing with the high-risk pregnancy, early delivery often is necessary. Centers caring for the high-risk mother and fetus cannot rely on the fetogram for evidence of maturity.

Since Gluck's initial report on the use of the L/S ratio to assess pulmonary maturity, many other reports have appeared. Many have supported the accuracy he reported, but others have found a high incidence of false negatives.[19,21,22,38]

Since the FST or rapid surfactant test was introduced by Clements in 1972, the exact role of the FST has been as a screening test primarily.[6,20,27,30,32,33,39,40] If positive, then no further tests would be performed, but if negative, then an L/S ratio evaluation would be made. Other authors have felt that the FST is suitable for use in outlying maternity units where no other fetal lung maturity tests are available.[5,41] Mukherjee felt that the accuracy of the FST should place it among the routine tests used to evaluate all amniotic fluids.[34] Roux and Keniston even suggested that there were less false negatives with the FST,[4,7] and that it should replace the L/S ratio.[7]

Our data confirms that the false-negative rate is quite high with both the L/S ratio and the FST. The false-positive rate with both tests is nearly zero. In our series, the L/S ratio often was mature in the presence of a false-negative FST. Likewise, in four cases of severe toxemia at 32 weeks' gestation, it appeared that the accelerated pulmonary maturity that often accompanies fetal stress was detected by the FST but not by the L/S ratio test. In high-risk obstetric patients in which preterm delivery is anticipated, both the L/S ratio and the foam stability test should be employed.

Acknowledgments: Charles Miller, M.D. interpreted the x-ray films; Janye Blayne, Barbara Wolk, and Ivan Pecic performed the laboratory procedures; and Patricia Drillien assisted in manuscript preparation.

IMMKE CIRCLE LEASING INC

Endorsed Leasing Company
Of The Ohio State Medical Association

Immediate delivery on many 1978 models

We lease all foreign and domestic makes and models
including Mercedes, Jaguar, Porsche, etc.

Many people think of leasing as just automobiles.
We do that too, but, in addition, we want to lease you any professional equipment.

Immke Circle Leasing, Inc.
32 South Fifth Street
Columbus, Ohio 43215

Telephone 614-228-1701 or Toll Free 1-800-282-0256

We create impressions...

Impressions for physicians who are concerned about their patients' peace of mind. We design professional environments with a personal touch. If you would like to make an impression, contact us. We're Medical Interiors, a division of the Wendt-Bristol Company.



medical interiors

a division of
THE WENDT-BRISTOL CO.
1107 dublin road p.o. box 144
columbus, ohio 43216

AMERICAN SURGICAL TRADE ASSOCIATION A.S.T.A.

☐ please send a brochure explaining your design concepts.
☐ I'm interested in learning more about MEDICAL INTERIORS.

WB the wendt-bristol company

NAME

ADDRESS

CITY STATE ZIP

OSMJ - 5/78

Elevation of Serum Uric Acid Levels in Patients with Seizures

George W. Paulson, M.D.

Four of 20 patients admitted to Riverside Methodist Hospital during one year because of an acute, major motor seizure had a transient elevation of uric acid in the serum. A chart review of 5,000 consecutively recorded uric acid levels revealed 55 patients with an elevated uric acid level above 10 mg per 100 ml, and three of these with otherwise inexplicable hyperuricemia had recently had a seizure. A transiently elevated uric acid value may follow a recent, major motor seizure, perhaps due to tissue acidosis or hypoxia. When there is a history of unexplained, brief unconsciousness, such transient hyperuricemia may suggest a seizure disorder.

A TRANSIENT ELEVATION of serum uric acid level may be noted in the first 24 hours after a severe epileptic seizure, and this had been generally accepted locally as has been reported.[1,2] This minor observation has not been documented in the neurologic literature. In an effort to confirm this association, charts of all patients admitted to Riverside Methodist Hospital in Columbus, Ohio because of an acute seizure were reviewed. In addition, results of tests for uric acid levels performed during December of 1975 were surveyed. Four out of 20 patients admitted with a primary admission diagnosis of an acute, major motor seizure had an elevation of uric acid of above 10 mg per 100 ml (normal 2.5 mg per 100 ml to 8.0 mg per 100 ml). A follow-up determination was made on three of these four, and the serum uric acid level had returned to normal within two days. A review of 5,000 consecutive uric acid determinations during December of 1975 revealed 55 patients with uric acid values above 10 mg per 100 ml. Chart review of these 55 patients showed that three of them had recently had a seizure. This was the only apparent explanation for the elevation in uric acid level and in all three, the level of uric acid had returned to normal within five days. Each of these three had been admitted with another major diagnosis (brain tumor, fever, cerebrovascular accident), but each had had a major motor seizure in the 24 hours before the uric acid value was obtained. The other 52 cases with hyperuricemia included patients with congestive heart failure, severe cardiac or pulmonary disease, and complex renal disorders. In almost all other cases with hyperuricemia, there was at least a modest elevation of blood urea nitrogen (BUN) or liver enzymes. Two patients had clinical gout with an elevation of uric acid secondary to this. None of the three cases detected by survey of uric acid values was admitted as a case of primary seizure disorder, nor was hyperuricemia or the seizure that occurred in the hospital mentioned as a discharge diagnosis.

Comment

From clinical observations in the past decade, the elevation of uric acid levels in patients with seizures has been considered more common in individuals who are young, in those who had extremely severe motor seizures, and in alcoholics. Many of the alcoholics admitted to this community hospital are young and vigorous, and their seizures can be exceptionally severe. Almost all patients with a uric acid level above 10 mg per 100 ml will have a clear metabolic or physiologic explanation for such elevation; and the reason usually is apparent even before complete laboratory results are obtained. Transient elevation of uric acid rarely is a cause for any clinical concern, and even persistent hyperuricemia often can be safely ignored when found in association with liver or renal disease. Leukemia can cause considerable elevation in uric acid; and there is a clinical impression of a linkage, especially in children, of very high levels of uric acid in leukemia with hyperactivity and irritability.

An elevation in uric acid is of potential diagnostic value in two situations. The first is the common problem of admission for an unexplained, transient episode of syncope or confusion. Transient elevation of uric acid

Dr. Paulson, Columbus, Neurologist, Riverside Methodist Hospital; and Clinical Professor of Neurology, The Ohio State University College of Medicine.

Submitted July 18, 1977.

in such patients may indicate that a seizure occurred preceding admission, and the seizure could have been the primary reason for the syncope.

A second diagnostic consideration involves the elevation of uric level seen in toxemia. Uric acid above the normal level in preeclamptic patients can correlate with a heightened possibility of eclamptic seizures.[3] Elevation of uric acid will be of limited prognostic value in toxemia if the patient has already had a seizure, because the seizure itself may have transiently elevated the value of uric acid.

The reason for an association between seizures and hyperuricemia is not known. Saugstad[1] has suggested a role for tissue hypoxia with hypoxanthine initially accumulating and then transformed to urate by xanthine oxidase in the liver following a seizure. Tissue acidosis may also play a role in the production of hyperuricemia, or severe muscle exercise itself may be causal. In some individuals with hyperuricemia, exceptionally severe and spasmodic muscle activity has occurred at the time of the seizure. The extreme muscle spasm may lead to increased production of lactate and other organic acids. Lactate preferentially inhibits urate secretion by the proximal tubule since both are secreted by similar mechanisms. If lactate does produce hyperuricemia indirectly, it would thus appear likely that an elevation of lactate levels might accompany the elevation of uric acid levels in patients who have had a recent seizure.

References

1. Saugstad OD: Letter: Hyperuricaemia and epileptic seizures: a possible explanation. *Lancet* 2(7936):665, 1975.
2. Warren DJ, Leitch AG, Leggett RJE: Hyperuricaemic acute renal failure after epileptic seizures. *Lancet* 2 (7931):385-387, 1975.
3. Ferris TF: Toxemia and Hypertension, in *Medical Complications During Pregnancy* (Burrow GN and Ferris TF, eds), Philadelphia, W B Saunders, 1975, pp 53-92.

we can provide some form of health insurance to . . .

99%

of OSMA members—regardless of health history

Comprehensive protection is available for you and your family with the OSMA sponsored Hospital Confinement Insurance Plan, comprehensive Major Medical Insurance and the Excess Major Medical Insurance Plan. Also available to Ohio physicians are Disability Income Coverage, Practice Overhead Expense Coverage, Life Insurance and Accidental Death, Dismemberment and Disability Insurance. Choose the plans that fill your insurance needs and send the coupon today for complete details. Or better yet for immediate information, call us collect!

Spencer W. Cunningham
DANIELS-HEAD & ASSOCIATES, INC.
Daniels-Head Building
Portsmouth, Ohio 45662
Telephone 614/354-4561

I have checked the plans in which I am most interested. Please send me complete details on how I can take advantage of this high value insurance protection at low group rates.

OSMA SPONSORED PLANS
- ☐ HOSPITAL CONFINEMENT INSURANCE PLAN
- ☐ COMPREHENSIVE MAJOR MEDICAL INSURANCE
- ☐ EXCESS MAJOR MEDICAL INSURANCE

ALSO AVAILABLE TO OHIO PHYSICIANS
- ☐ DISABILITY INCOME PROTECTION
- ☐ ACCIDENTAL DEATH, DISMEMBERMENT and DISABILITY INSURANCE
- ☐ PRACTICE OVERHEAD EXPENSE PROTECTION
- ☐ LIFE INSURANCE

Name_____
Address_____
City_____
State_____ Zip_____

THE OHIO STATE Medical Association

Maternal Health in Ohio

Maternal Mortality Report for Ohio --- 1974*

The OSMA Committee on Maternal and Neonatal Health

THE COMMITTEE ON MATERNAL and Neonatal Health presents its 20 annual research summary for the year 1974. The report is published in compliance with the directive creating this Committee in 1954.

Statistics for the year 1974 from the Ohio Study are published in a uniform manner to facilitate comparison with similar past and future reports. Terminology and nomenclature used throughout the study were adopted after careful deliberation. They closely adhere to those prescribed in the International Classification.

The Division of Vital Statistics, Ohio Department of Health, reported 160,199 live births in Ohio during 1974. This corresponds to one live birth every 3.3 minutes and is associated with one infant death every 3½ hours. In 1974, there were also 1,745 stillbirths reported; most occurred in Cuyahoga County, next Franklin County, then Hamilton County. The greatest number of stillbirths were reported in September 1974. However, surprisingly enough, the number of live births during 1974 showed only a slight decrease below the number reported during 1973 (160,436).

From the Ohio Maternal Mortality Study, the Committee found only 27 maternal deaths in 1974. This maternal mortality rate equalled 0.17 per 1,000 live births, or 1.68 per 10,000 live births. Among these deaths, there were seven very unusual cases including four ectopic pregnancies of which three were not operated. Seven of the 27 patients died undelivered. Of these, three were ectopic pregnancies, two were abortions, and two were 28-week gestations. There was one reported death associated with legal abortion, the first one.

Less than 50% of the deaths were voted preventable. Of these, personnel responsibility was predominant. Again, hemorrhage led the number of maternal deaths as a primary cause, while pulmonary embolism was singly predominant among "other causes."

Having watched the trends in Ohio maternal deaths for over two decades, the Committee continues to feel that a number of cases are omitted from discovery or reporting, either accidentally or purposely. Within customs and current trends, it is reasonable to assume that threats of malpractice suits have influenced this practice. Yet in the Ohio Study, as well as other educational media, we must continue factual reporting of cases to promote medical education and maternal and neonatal safety.

*Extracted from Report of The Committee on Maternal and Neonatal Health approved by the OSMA Council, December 17, 1977.

Ohio Maternal Mortality Study Statistics for 1974

Total Live Births in Ohio, 1974		160,199
(Total cases in files, 20 years, 1955-1974 = 1,733)		
Total Cases Studied, 1974		33
Cases not studied due to lack of information		2
Undetermined		0
Maternal Deaths (classified)		27
Nonwhite		9
White		18
Age:		
Teens		2
20s		18
30s		5
40s		2
Parity:		
Primigravidae		6
Multiparae		18
Unknown		3
Place of Death:		
Hospital		23
Home		3
Other		1
Place of Birth:		
Hospital		16
Home		3
Other		1
Type of Delivery:		
Not recorded		0
Operative		14
Nonoperative (spontaneous)		6
Not delivered		7
Route of Delivery:		
Not recorded		0
Vaginal		10
Cesarean		9
(antemortem)	7	
(postmortem)	2	
Laparotomy (ectopic preg.)		1
Not delivered		7
Case Classification (when death occurred):		
Not known		0
Group I (fr. concept. to 20th wk.)		5
Group II (fr. 20th wk. to 28th wk.)		2
Group III (fr. 28th wk. through term)		3
Group IV (postabortal, postpartum)		17
Autopsies		
(Includes 5 coroners')		14
Prenatal care (apparent from data sheets)		
None		0
Unknown or not reported		4
Adequate		14
Inadequate		2
Excluded (ectopic preg. and abortion)		7
Classification of preventability:		
Nonpreventable		14
Preventable (avoidable factor)		13
Patient responsibility (P_1)	3	
Personnel responsibility (P_2)	7	
Both P_1 and P_2	3	
P_3	0	
Classification of Primary Causes of Death:		
Hemorrhage		*11*
Abortion, without sepsis (suction abortion)		1
Afribrinogenemia		1
Abruptio	1	
Am. fl. embolus	0	
Dead fetus	0	
Ruptured uterus	0	
Atony, uterine, postpartum		1
Ectopic pregnancy without sepsis		4
Laceration, extrauterine		0
Placenta praevia		0
Retained placenta		0
Ruptured uterus (no afibrin.)		2
Other		2
Infection		*3*
Abortion, alleged "criminal"		0
Abortion, septic, spontaneous		0
Upper respiratory infection		0
Peritonitis		1
Septicemia (puerperal sepsis)		1
Septicemia (other)		1
Other		0
Toxemia		*1*
Acute yellow atrophy		0
Hypertension, chronic (incl. hypertension with cerebrovascular hem.)		0
Eclampsia		0
Preeclampsia		0
Renal disease		1
Other		*13*
Amniotic fl. emb. (no hemorrhage)		1
Anesthesia		1
(general)	0	
(regional)	1	
Brain, edema, unspecified		1
Cardiac disease		2
Cerebrovascular hemorrhage (no tox.)		1
Chorioepithelioma		0
Diabetes		0
Hydatid mole		0
Lower nephron nephrosis		0
Pulmonary edema		0
Pulmonary embolus		4
Renal disease, chronic, unspecified		1
Trauma, massive, external		1
All other		1
High-risk "OB" patients (51%)	14	
High-risk condition related to cause of death (17%)	5	

Preparing the Resident for Continuing Medical Education

Stephen F. Pariser, M.D.
Bruce A. Jones, M.D.
Rudolf Kaelbling, M.D.*

Continuing Medical Education (CME) is required for relicensure in many states. The authors describe the incorporation of CME principles into residency training in psychiatry at The Ohio State University College of Medicine. After basic courses in the first year, each resident must complete 200 hours of academic work yearly, which is approved by a resident-faculty committee. Annual comprehensive examinations assess the resident's performance and the success of the teaching program.

THE KNOWLEDGE AND SKILLS required of the psychiatrist at the completion of his training constitute a formidable list.[1,2] The way to achieve the desired result is in dispute, a reflection of the changing demands which society places upon psychiatry as a discipline.[3] One such demand is that psychiatrists, as all physicians, shall be continually accountable to society at large. This has led to demands for recertification and changes in certification[4,5] and to the requirement for continuing medical education (CME) as a way of life for physicians.[6] Another important change in recent years has been an increasing involvement of students in defining their education. The medical specialty, psychiatry, has felt this as well, with surveys of residents' attitudes toward their programs[7] and proposals for "self-education" of residents in psychiatry.[8]

The social turmoil has affected the training program in psychiatry at The Ohio State University College of Medicine. CME is now required for relicensure in this state, as in some others. And residents in this training program were becoming more open with their dissatisfaction with the academic part of their training experience. We found these demands merging and leading us toward an integration of CME with the residency training program. With the cooperation of The Ohio State University College of Medicine, the residents formulated a proposal which accomplished four goals:

1. A core curriculum more compact, more specific, and better defined than previous course offerings.
2. Proficiency examinations before core curriculum courses, allowing residents to demonstrate competence in a certain area and thereby omit that course.
3. Advanced credits required of each resident and earned on a CME model according to personal needs or interests.
4. A comprehensive examination administered annually to provide faculty and resident with feedback.

The New Curriculum

The new core curriculum is composed of courses which cover basic concepts and new developments in broad areas such as: psychiatric diagnosis, psychodynamics, psychopharmacology, epidemiology, and consultation-liaison psychiatry. This core curriculum is required of all first-year residents. Instruction is four hours weekly and involves case presentations, audio-visual materials, and seminars, as well as lecture-discussion sessions. Residents who demonstrate proficiency in a given area will be excused from that course, but are expected to devote an equivalent amount of time to some other academic activity approved by the Post-MD Education Committee. This committee has a first-year and an advanced-resident representative (elected by the residents). It coordinates and updates course offerings based on syllabus, texts, examinations, and other feedback.

Following successful completion of the first year's clinical and didactic experience, there are a variety of options offered. All seminars and classes are optional now but, as in CME, the residents must take electives. Residents are free to select from a wide array of courses, seminars, and individualized study or research programs, the specific subject material which is agreed upon by both residents and faculty. All activities must be approved by the Post-MD Education Committee and are assigned units of academic credit. A minimum of ten such "credits" must be earned each month and at least 200 each year.

*Deceased
Dr. Pariser, Columbus, Attending Staff, The Ohio State University Hospitals; Provisional Staff, Riverside Methodist Hospital; and Assistant Professor of Psychiatry, Assistant Professor of Family Medicine, Clinical Instructor in Obstetrics and Gynecology, The Ohio State University College of Medicine.
Dr. Jones, Columbus, Attending Staff, The Ohio State University Hospitals; Staff Psychiatrist, Veterans Administration Clinic at The Ohio State University; and Assistant Professor of Psychiatry, The Ohio State University College of Medicine.
Dr. Kaelbling was Professor and Coordinator of Residency Training, Department of Psychiatry, The Ohio State University College of Medicine. He stimulated the development of the program described here and made extensive revisions in early drafts of this article prior to his death in December 1976.
Submitted April 1, 1977.

Credits are reported on a monthly form by the resident; these then are screened by a committee.

Each credit is defined as the equivalent of one hour of seminar or classroom activity. Included in the range of possibilities for credit are:

1. Formal didactic courses;
2. Participation in seminars;
3. Attendance at departmental grand rounds (a monthly event);
4. Participation in formal case conferences and lectures offered for medical students by the department;
5. Tutoring medical students. All medical students rotating through psychiatry get a list of readings and instructional tests and are assigned a personal tutor, one to a student.
6. Supervised research. Research is optional; the stimulus must come from the resident, supported by individual faculty advisors. Research can be done in basic science, clinical psychiatry, or psychosocial factors in physical illness.
7. Computer-assisted courses of self-instruction developed by The Ohio State University College of Medicine;
8. CME programs on The Ohio State University College of Medicine Radio-Television CME network; and
9. Attendance and participation in professional meetings.

The list of possibilities for credit is open-ended and their similarity to various categories of CME credit is evident. This approach has stimulated the residents to organize weekly, noon-hour conferences with guest speakers in the areas of interest which might range from "Clinical Psychiatry in the Prison Setting" to "The Role of the Adrenergic Nervous System in Acute Coronary Heart Disease." The conferences have been well accepted by both faculty and residents. These offerings are designed to meet the requirements for CME newly enacted in Ohio. The courses also are open to alumni and professionals-at-large for the same purpose. This emphasizes the fact that learning still goes on for those who have completed formal training. While recertification in psychiatry is not required now, one may need to demonstrate learning after formal training at sometime in the future.

Examination Format

At the *beginning* of his training, each resident is required to take an annual comprehensive examination, which is a written examination similar to the written portion of the American Board of Psychiatry and Neurology Examination. The examination provides "baseline" information on all residents, as well as the opportunity for residents to obtain proficiency credit. At the beginning of the second year, a new examination demonstrates achievement in core curriculum areas and furnishes the basis for learning in that year. By the beginning of the third and final year, the resident hopefully is able to perform well on the examination. In the event the resident does not do well in some areas, there is an additional year of training in which to remedy shortcomings. The resident who does well in all areas is encouraged to develop his own program, following his interests in medicine to express his potential.

Instructors learn from these examinations what course material is well known to residents and might be curtailed. They discover areas of course work not mastered by the residents, and they plan future teaching accordingly. A coordinating committee uses the examination results in comparison with the syllabus to determine the overall accomplishments of the program. Furthermore, the examination is valuable to residents in preparing for specialty board examinations. A majority of the faculty also is taking the examination. Their performance can help to eliminate poor questions and to set standards.

Discussion

A training program to prepare residents for CME must avoid two extremes. One is the traditional approach of "teacher knows best." The other is the "laissez faire" of complete reliance on each individual's proper motivation and good judgment. We have endeavored to avoid both of these extremes by providing a minimum requirement in the form of a core curriculum which is subject to continual review in the light of examination results. Gradually, the individual resident gets ever-increasing freedom to pursue personal interest but is held to a comparison of his performance with that of his peers. The residents thus learn to function within the model of CME *during* their training. We hope this will enable them to use CME on a post-training level more effectively.

References

1. Langee H, Glick ID, Hoffman B: The requirements of a psychiatric residency program circa 1972. *Am J Psychiatry* **130**:1151-1152, 1973.
2. Yager J, Pasnau RO: The educational objectives of a psychiatric residency program. *Am J Psychiatry* **133**:217-220, 1976.
3. Grinker RR: The future educational needs of psychiatrists. *Am J Psychiatry* **132**:259-262, 1975.
4. Taylor RL, Torrey EF: The pseudo-regulation of American psychiatry. *Am J Psychiatry* **129**:658-663, 1972.
5. Frazier SH: A commentary on "The pseudo-regulation of American psychiatry." *Am J Psychiatry* **129**:664-668, 1972.
6. Keyes JA, Wilson MP, Becker J: The future of medical education: forecast of the Council of Deans. *J Med Educ* **50**:319-327, 1975.
7. Greden JF, Casariego JI: Controversies in psychiatric education: a survey of residents' attitudes. *Am J Psychiatry* **143**:270-274, 1975.
8. Taylor RL, Torrey EF: The self-education of psychiatric residents. *Am J Psychiatry* **128**:1116-1121, 1972.

Clinical experience & continuing confidence

KAON® ELIXIR was introduced in **1954,** followed by KAON® TABLETS in **1963.** Decades of clinical experience indicate acceptability, effectiveness, and safety in the majority of patients; should abdominal pain occur, therapy should be discontinued. Both have been taken by patient after patient, day after day, year after year, to correct potassium deficiencies. Both have consistently demonstrated their value when diet alone is inadequate for potassium replacement.

Kaon® Elixir
(potassium gluconate)

Kaon® Tabs
(potassium gluconate)

BRIEF SUMMARY
Kaon Tablets/Kaon Elixir

KAON® (potassium gluconate) TABLETS

Description: Each sugar-coated tablet supplies 5 mEq. of elemental potassium (as potassium gluconate 1.17 Gm.). Kaon Tablets are sugar coated, not enteric coated, which favors dissolution in the stomach and absorption before reaching the small intestine where the lesions with enteric potassium chloride have occurred. The sugar coating merely adds to palatability and ease of swallowing, not to delay absorption as does the enteric coating.
Indications: Oral potassium therapy for the prevention and treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. It may be used in the treatment of cardiac arrhythmias due to digitalis intoxication.
Contraindications: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause.
Warning: There have been several reports, published and unpublished, concerning nonspecific small-bowel lesions consisting of stenosis, with or without ulceration, associated with the administration of enteric-coated potassium tablets alone or when they are used with nonenteric-coated thiazides or certain other oral diuretics. These small-bowel lesions have caused obstruction, hemorrhage and perforation. Surgery was frequently required and deaths have occurred. Available information tends to implicate enteric-coated potassium salts, although lesions of this type also occur spontaneously. Therefore, coated potassium-containing formulations should be administered only when indicated and should be discontinued immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Coated potassium tablets should be used only when adequate dietary supplementation is not practical.
Precautions: In response to a rise in the concentration of body potassium, renal excretion of the ion is increased. With normal kidney function, it is difficult, therefore, to produce potassium intoxication by oral administration. However, potassium supplements must be administered with caution, since the amount of the deficiency or daily dosage is not accurately known. Frequent checks of the clinical status of the patient, and periodic ECG and/or serum potassium levels should be made. High serum concentra-

Time is the test of all things.

1954
1978



BRIEF SUMMARY

Indications: Oral potassium therapy for the prevention and treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. May be used in the treatment of cardiac arrhythmias due to digitalis intoxication.

Contraindications: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause.

Precautions: Potassium intoxication by oral administration rarely occurs in patients with normal kidney function, however, potassium supplements must be administered with caution, since the amount of the deficiency or daily dosage is not accurately known. Frequent checks of the clinical status of the patient, and periodic ECG and/or serum potassium levels should be made. High serum concentrations of potassium ion may cause death through cardiac depression, arrhythmias or arrest. This drug should be used with caution in the presence of cardiac disease.

In hypokalemic states, especially in patients on a low-salt diet, hypochloremic alkalosis is a possibility that may require chloride as well as potassium supplementation.

Adverse Reactions: Nausea, vomiting, diarrhea, and abdominal discomfort have been reported. The most severe adverse effect is hyperkalemia.

Overdosage: Potassium intoxication may result from overdosage of potassium or from therapeutic dosage in conditions stated under "Contraindications". Hyperkalemia, when detected, must be treated immediately because lethal levels can be reached in a few hours.

Kaon® Elixir
(potassium gluconate)
20 mEq per 15 ml

WARREN-TEED
LABORATORIES, INC.
DIVISION OF **ADRIA LABORATORIES INC.**
COLUMBUS, OHIO 43215

Intoxication by Datura Stramonium

Ivan A. Lopez, M.D.

Datura stramonium intoxication is seasonal, occurring toward the fall of the year. An understanding of the neurologic problems of the syndrome produced by the intoxication of the "Jimson weed" prompted the use of antagonist substances. Clinical data are presented, and an effective therapeutic approach to this problem is proposed.

DATURA STRAMONIUM has many synonyms. It also is known as Jimson weed, Jamestown weed, California poppy, thorn apple, apple of Peru, teasel burr, and tolguacha.

The use of Datura dates back to 2,000 to 3,000 years ago; from Babylonian and Assyrian tablets, we learn that the ancients used the thorn apple, among other toxic plants, for its properties. It still is used today in the United States by people of Appalachia to fashion poultices of Jimson weed for treatment of wounds.

This weed has a world-wide distribution in temperate and subtropical areas; it attains a height up to 1.5 meters, is herbaceous and widely branching, and has polygonal, spinous leaves arising from an erect stem. The flowers are large, trumpet-shaped, white and showy; the nectar is poisonous. The thorn apple is oval, measures about 2 x 4 cm, is spinous in appearance, and is green when fresh and brown when dry. When dry, the capsule usually splits along four regular valves, and the seeds are numerous (from 150 to 200), brown, and measure 1 mm to 2 mm. They are poisonous, containing numerous alkaloids including atropine and hyoscyamine, both having nicotinic and muscarinic effects.

Young people looking for new emotions recently have been taking the seeds in various disguised forms hoping to obtain a "high." The seeds produce side effects on the central nervous system, characterized by hallucination, disorientation, amnesia, and feelings of unreality. Besides these symptoms and side effects, the ingested seeds produce a variety of systemic disturbances including intense thirst, impaired vision, convulsions, coma, and death.

The outbreak of cases of intoxication with seeds which produce a secondary effect of an atrophine-like picture prompted this study. Five cases of intoxication by Datura stramonium seen and treated at a community hospital in Northeastern Ohio in the fall of 1976 are reported herein.

Clinical Data

Five patients, ranging in age from 14 years to 23 years, were seen and treated at a community hospital in the two-month period of September and October 1976.

A 19-year-old man was brought to the emergency room with flushed skin, dry mouth, mydriasis, oral temperature of 36.3 C (97.4 F), pulse rate 132 beats per minute, respiration 24 per minute, and blood pressure 150/76 mm/Hg. He stated he had eaten "wild seeds," but he refused to be admitted to the hospital and left against medical advice.

An 18-year-old man was brought to the emergency room with flushed skin, dry mouth, mydriasis (pupils 4 mm nonreactive), increased deep tendon reflexes, hallucinations, irrational behavior, amnesia, oral temperature 37.2 C (99.0 F), pulse rate 120 beats per minute, blood pressure 170/90 mm/Hg, and respiration 26 per minute. His friends stated he had taken "wild seeds" about eight hours prior to admission. In the emergency room, he was given ipecac, 30 cc, which had no effect, and phenobarbital, 50 mg intramuscularly. Result of urinalysis was normal. He was placed in a quiet, dark room and intravenous therapy (dextrose 5% plus half-normal saline solution, 3,000 cc) was begun. Results of complete blood count (CBC), serum glutamic oxaloacetic transaminase (SGOT), lactic dehydrogenase (LDH), alkaline phosphatase, serum uric acid, and serum protein tests, as well as chest roentgenograms, were all within normal limits.

The patient was kept in the hospital one day, at which time his mydriasis was 3 mm and the pupils started to react to light. He was alert and oriented. He admitted that he had taken about one-quarter of a Jimson weed nut to obtain a "high." He was discharged in satisfactory condition.

A 17-year-old white man presented to the emergency room with a history of ingestion of wild seeds. The examination revealed a combative, restless, man who had flushed skin, dry mouth, tachycardia 128 beats per minute, blood pressure 130/90 mm/Hg, and rectal temperature 38.9 C (102.0 F). Urinalysis revealed a density of 1.006 with large amounts of red blood cells. He was given Narcan,® which produced no results, and phenobarbital, 10

From the Neurology Service, Massillon City Hospital, Massillon, Ohio.
Dr. Lopez, Staff Member, Massillon City Hospital.
Submitted October 11, 1977.

mg intravenously. He was admitted to the intensive care unit, where he became comatose and developed general convulsions. His skin became warmer and redder; his pupils were fixed and dilated. Treatment consisted of intravenous therapy (dextrose 5% plus one half-normal saline, 3,000 cc, in 24 hours), diazepam, 5 mg intravenously, alcohol sponges to decrease the temperature, Lanoxin,® and observation of vital signs. Serum electrolytes, urea, protein, alkaline phosphatase, bilirubin, cholesterol, uric acid, and serum calcium values were normal. Repeat urinalysis revealed a density of 1,004 and decreased red blood cells. Electrocardiogram indicated tachycardia. The second day, the electrocardiogram was normal, the patient was awake and having normal diuresis, but his pupils remained fixed in mydriasis. He developed a tremor with numbness in the right-upper arm. On the third day, he was removed from the intensive care unit. At this time, the blood pressure lowered to 112/70 mm/Hg, the pupils still were mydriatic but they began to react to light. On the fourth day, his condition was satisfactory and he was discharged, although he still had tremor and numbness in the right-upper arm. Follow-up of this patient 23 days after admission revealed no sequela.

A 23-year-old white man was brought to the emergency room with a history of ingestion of wild seeds ten hours prior to admission. On examination, he was disoriented, uncoordinated, hallucinating. His blood pressure was 120/80 mm/Hg, pulse rate 100 beats per minute, respiration 22, and temperature (rectal) was 36.4 C (97.6 F). His skin was dry, warm, and red; pupils were fixed in maximum mydriasis; deep tendon reflexes were hyperactive; and plantar reflexes were flexor. He was difficult to control, and he was given physostigmine, 1 mg intravenously, and 1 mg intramuscularly. Results of urinalysis and CBC were normal. He was admitted to the hospital intensive care unit. Twenty minutes later, he was totally alert, coordinated, had good memory of the events surrounding his intoxication, and recalled he had ingested "about one-quarter of a Jimson weed apple." His pupils still were dilated and nonreactive to light. He was started on supportive intravenous therapy. His electrocardiogram was within normal limits, and he was observed for vital signs. Physostigmine therapy was discontinued, and he was observed and was treated conservatively. Upon questioning six hours later, he stated he was "feeling nice, floating in the air." His pupils still were in mydriasis and nonreactive. He recovered gradually within the next 24 hours and was discharged totally asymptomatic.

Discussion

Intoxication by Datura stramonium has been widespread recently, and 14 cases had been reported in a Northern Ohio county at time of the writing of this article. Although no one case among those reported by hospitals in the area has been fatal, one of the patients not reported in this paper has been sent to a mental institution; one of the patients reported in this paper developed convulsions and coma.

The striking neurologic picture of atropine-like intoxication prompted me to approach the treatment from the neurologic standpoint; it was deducted that a medication with cholinergic effect would act as an atropine antagonist. A review of the literature confirmed this presumption,[1,2] and physostigmine was given a first-choice consideration.[1,3,4] When a new case of Datura intoxication was seen in the emergency room of our hospital, physostigmine was given and the results were dramatic. The dose adminstered was 1 mg intramuscularly and 1 mg intravenously. The rationale of the treatment also must include measures intended to reduce the effects of the toxic upon the nervous system, the cardiovascular system, the kidneys, and the temperature control. Intravenous therapy should be started and the kidneys forced to eliminate urine. The temperature should be kept normal with the assistance of ice or a thermo-blanket. If the temperature is not controlled, a heat stroke or malignant hyperthermia could develop. The patient should be kept quiet and in a dark room to protect the eyes from excessive light. If agitated, the patient should be cautiously sedated with phenobarbital; convulsions should be treated with diazepam given intravenously; the cardiac rate should be brought to normal by digitalics or propranolol therapy.

Although physostigmine is not an antidote of atropine, it acts as an antagonist, restoring the disrupted equilibrium between the sympathetic and the parasympathetic nervous system. The theoretic principles of the antagonist effect of physostigmine (or neostigmine, which also could be used) were satisfactory in clinical practice. Hospital stay is markedly reduced when the proper treatment is given.

As intoxication by Datura is increasing among youngsters looking for "highs," proper treatment of the condition is urged. With this entity becoming more widespread, the definite picture should have an appropriate name: I propose the name "Daturosis" for this condition.

Generic and Trade Names of Drugs

Naloxone hydrochloride— Narcan (Endo Laboratories)
Digoxin— Lanoxin (Burroughs Wellcome Co.)

References

1. Rumack BH: Anticholinergic poisoning: treatment with physostigmine. *Pediatrics* 52(3):449-457, 1973.
2. Slovis TL, Ott JE, Teitelbaum DT, et al: Physostigmine therapy in acute tricyclic antidepressant poisoning. *Clinical Toxicology* 4(3):451-459, 1971.
3. Gowdy JM: Stramonium intoxication: review of symptomatology in 212 cases. *JAMA* 221:585-587, 1972.
4. Greene LT: Physostigmine treatment of anticholinergic-drug depression in postoperative patients. *Anesth Analg* 50(2): 222-226, 1971.

Ohio State Medical Association Obituaries

THEODORE ALBERTOWICZ, M.D., Chillicothe; Tufts University School of Medicine, Boston, 1940; age 62; died February 28; member OSMA and AMA.

ROBERT ELLISON, M.D., Peebles; University of Cincinnati College of Medicine, 1932; age 71; died March 6; member OSMA and AMA.

F. GRAHAM FALLON, M.D., Cleveland; St. Louis University School of Medicine, 1928; age 77; died March 3; member OSMA and AMA.

EDWARD FRIEDMAN, M.D., Cincinnati; University of Cincinnati College of Medicine, 1929; age 75; died March 10; member OSMA and AMA.

WILLIAM T. GORDON, M.D., Cincinnati; St. Louis University School of Medicine, 1937; age 65; died March 3; member OSMA and AMA.

CHARLES W. HOYT, M.D., Cincinnati; Hahnemann Medical College and Hospital of Philadelphia, 1940; age 64; died February 13; member OSMA and AMA.

ROBERT A. JENKINS, M.D., Kent; Western Reserve School of Medicine, 1952; age 54; died February 22, 1978.

JOHN A. MITCHELL, M.D., Newark; Cornell University Medical College, 1952; age 55; died January 1978; member OSMA and AMA.

EDWARD J. PURCHLA, M.D., Toledo; Loyola University Stritch School of Medicine, 1935; age 65; died February 27; member OSMA and AMA.

ROBERT SCHWALENBERG, M.D., Tiffin; University of Rochester School of Medicine and Dentistry, 1952; age 59; died December 28; member OSMA and AMA.

JEWELL VAN DE WATER, M.D., Bellevue; Ohio State University College of Medicine, 1950; age 57; died March 12; member OSMA and AMA.

DONALD WILLIAMS, M.D., Marietta; University of Cincinnati College of Medicine, 1943; age 61; died March 1; member OSMA and AMA.

Librax®
Each capsule contains 5 mg
chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

ROCHE
Roche Products Inc.
Manati, Puerto Rico 00701



In treating irritable bowel syndrome*

Enhance your therapeutic expectations with

Librax®

Each capsule contains
5 mg chlordiazepoxide HCl
and 2.5 mg clidinium Br.

antianxiety/antispasmodic/antimotility

Librax is unique among G.I. medications in providing the specific antianxiety action of LIBRIUM®(chlordiazepoxide HCl) as well as the potent antispasmodic and antimotility actions of QUARZAN®(clidinium Br) for adjunctive therapy of irritable bowel syndrome.

ROCHE

*Librax has been evaluated as possibly effective for this indication.
Please see brief summary of prescribing information on preceding page.

THE OHIO STATE Medical Association Cancer Education Series*

Support of the Cancer Patient and His or Her Family

Thomas P. Bowlus, M.D.

THE CANCER PATIENT'S problems are multifaceted and require a supportive team effort to sustain hope, maintain normalcy, and to assist the patient and the family to continue to function. The team is composed of the family physician, the family minister, nurses, consulting physicians, volunteers, and anyone who comes in contact with the patient. The role of the family physician is critical since he directs the team in developing mechanisms for the patient and family to cope with the problem.

The role of the team member varies depending upon the problems of the patient and the family. Several problems may be present concurrently such as, debility, emotional instability, fear of pain, discomfort, disfigurement or death, and financial problems. Anger, depression, guilt, panic, denial, rejection by family and friends, and the patient's role change within the family also contribute to the problem.

As a family physician, I am an integral member of a team important to my patient and his or her family, but I am not capable of handling all of the medical and psychologic problems presented by the patient with a malignancy.

The chronology of a malignant disease presents the physician with changing problems and challenges for providing support for the patient and his or her family. The chronology of a fatal malignancy can be considered to consist of four phases: a prodromal phase, a phase of diagnostic study, a phase of physician-patient interrelationship, and finally, the terminal phase.

Prodromal Phase.— The patient frequently is not seen by the physician when the first symptoms or signs of cancer appear; but if there has been a good relationship between the doctor and the patient, the patient is more likely to seek medical advice promptly.

Phase of Diagnostic Study.— When the diagnosis of cancer has been established, the physician must decide how and what to communicate to the patient. The tempo for this communication is set by the patient, and the real issue is how and in what manner to tell him that he has cancer. I believe information of this type should not be given to unprepared patients, yet withholding information can cause great distress and anxiety. Truth concerning the presence of malignancy is most important, and the primary goal of communication is to facilitate the treatment process maintaining optimal physical, psychologic, logical, and social functioning.

When a child is ill, the parents frequently are unwilling to have the child made aware of his or her disease. I feel that it is difficult for the parents to hide their anxieties; and that if the child is told of the disease, it becomes much easier for the entire family to cope with the problems that arise. In this way, reasonably normal family life can be maintained. It should be made very clear that the physician is available to answer questions. Ample opportunity must be given for patients to vent their concern, and the physician must be responsive to the patient's special needs. Older patients frequently forget things they wish to ask their physician concerning their illness, and I ask my patients to make a list of questions before they return for another visit.

Phase of Established Physician-Patient Relationship.— Uncertainty about diagnosis is less an issue than the uncertainty concerning treatment and progress. At this time, management is particularly complex due to the necessity for frequent medical visits, the uncertain future, family stress, and the possibility of maladaptive coping,

Dr. Bowlus, Toledo, Active Staff and Chairman, Tumor Board, Riverside Hospital, and Active Staff and Executive Committee Member, St. Charles Hospital.

Submitted October 18, 1977.

The Journal is pleased to publish this series through the cooperation of the OSMA Committee on Cancer and the American Cancer Society, Ohio Division, Inc.

and emotional reactions of both the patient and/or his family.

The goals of communication at this point are (A) to maintain a realistic approach to treatment; (B) to sustain hope; (C) to manage maladaptive coping mechanisms; and (D) to maintain optimal contact with the family.

(A) A realistic approach is based on the recognition that no matter what symptoms are present, there always is something that can be done to give relief. I do not feel that overenthusiasm or extreme pessimism should be part of my response to the patient. I emphasize that I will be available and that the patient will not be deserted.

(B) Hope is the key that enables the cancer patient to cope with his/her problem. The doctor is a symbol of hope to the patient to provide support for living, not dying. Hope is the critical factor in a satisfactory doctor-patient relationship.

(C) Maladaptive coping aggravates the patient's suffering. The following symptoms or responses may be seen: denial, suppression, excessive regression, withdrawal, anger, depersonalization, and rationalization. These are a part of almost every patient's response. If I consider these symptoms to be excessive, I frequently call upon my psychiatric colleagues for assistance.

(D) Contact with the family. A family must be considered as a unit; what one member is told will be communicated to the others. This may pose a problem concerning the diagnosis, decisions regarding treatment, and how the family can mobilize their emotional and economic resources to adjust to a traumatic situation. Frequently, relatives are struggling with a variety of negative feelings, eg, anger at medical personnel, hidden resentment, guilt, and attempts to make up for their "shortcomings." These negative feelings can be resolved many times by the physicians' reassurance that they are doing everything possible to help the patient. Hopefully, this relieves the relatives of their feelings of guilt.

Terminal Phase.— During this phase, the major goals are to prevent a sense of hopelessness, helplessness, and loneliness; to preserve the dignity of the patient; to provide necessary medical support and care, eg., adequate pain medication; and to help the family with their grief, feelings of guilt, and assist the patient in facing the loss of life and the acceptance of imminent death.

Summary

The family physician is an important member of a team treating the cancer patient and the patient's family by honest communication and by emphasizing that whatever symptoms the patient presents, there always is something that can be done.

Practice Productivity® Inc.

Practice Productivity Inc. is a national medical management consulting firm which offers educational and motivational workshops in sound business concepts to practicing physicians, residents, office managers, and medical assistants. Practice Productivity (PPI) also provides nationwide consulting services to physicians at their private practice.

The professional staff of Practice Productivity consists of seasoned consultants with different backgrounds and many years of experience in solving the real problems of the practicing physician in either solo or group practice. Some background credentials of the staff are: psychologist, lawyer, accountant, pharmacist, medical office manager, educator, systems analyst, EDP (computer expertise), business administration. Such a multi-faceted staff enables PPI to relate to the multi-faceted circumstances found in most private medical practices.

For further information about consulting services or practicing physician, resident, office manager, or medical assistant workshops contact:

Duane M. Johnson, Ph.D.
Executive Vice President
Practice Productivity Inc.
2000 Clearview Avenue
Atlanta, Georgia 30340
(404) 455-7344

ANCEF® IV IM

brand of sterile

CEFAZOLIN SODIUM

(LYOPHILIZED)

For serious respiratory infections

due to susceptible indicated organisms



Bactericidal *in vitro* against susceptible strains*

IV/IM Dosage Flexibility

'Ancef' may be given either IM or IV at the same dosage schedule.

Most infections can be treated with 500 mg. to 1 gram every 8 hours.

(See complete prescribing information in *PDR* or SK&F literature for full dosage instructions.)

Well Tolerated

Infrequent phlebitis; no nephrotoxicity reported. Transient rises in BUN, SGOT, SGPT and alkaline phosphatase have been reported without clinical evidence of renal or hepatic impairment.

Before prescribing, see complete prescribing informotion in SK&F literoture or *PDR*. The following is o brief summory.

Indicotions: Ancef® (sterile cefazolin sodium, SK&F) is indicated in the treatment of the following serious infections due to susceptible organisms.

***Respirotory tract infections** due to *Streptococcus (Diplococcus) pneumoniae, Klebsiella* species, *Hemophilus influenzae, Staphylococcus aureus* (penicillin-sensitive and penicillin-resistant), and group A beta-hemolytic streptococci.

Injectable benzathine penicillin is considered to be the drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever.

'Ancef' is effective in the eradication of streptococci from the nasopharynx; however, data establishing the efficacy of 'Ancef' in the subsequent prevention of rheumatic fever are not available at present.

Genitourinory troct infections due to *Escherichia coli, Proteus mirabilis, Klebsiella* species, and some strains of enterobacter and enterococci.

Skin ond soft-tissue infections due to *S. aureus* (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci and other strains of streptococci.

Bone ond joint infections due to *S. aureus*.

Septicemio due to *Str. pneumoniae, S. aureus* (penicillin-sensitive and penicillin-resistant), *P. mirabilis, E. coli*, and *Klebsiella* species.

Endocorditis due to *S. aureus* (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci.

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causotive organism to 'Ancef'.

Controindicotions: 'Ancef' is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Wornings: BEFORE CEFAZOLIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS.

SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Antibiotics, including 'Ancef', should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Usage in Pregnancy—Safety of this product for use during pregnancy has not been established.

Usage in Infants—Safety for use in prematures and infants under one month of age has not been established.

Precautions: Prolonged use of 'Ancef' may result in the overgrowth of non-susceptible organisms. Careful clinical observation of the patient is essential.

When 'Ancef' is administered to adults or children with low urinary output because of impaired renal function, lower daily dosage is required (see dosage instructions in the package literature).

A false-positive reaction for glucose in the urine may occur with Clinitest® tablets; use glucose enzyme-type reagents.

Adverse Reactions: The following reactions have been reported. Drug fever, skin rash, vulvar pruritus, eosinophilia, neutropenia, leukopenia, thrombocythemia, and positive direct and indirect Coombs tests have occurred. Transient rise in SGOT, SGPT, BUN, and alkaline phosphatase levels has been observed without clinical evidence of renal or hepatic impairment. Nausea, anorexia, vomiting, diarrhea, and oral candidiasis (oral thrush) have been reported. Pain at the site of injection after intramuscular administration has occurred, some with induration. Phlebitis at the site of injection has been noted. Other reactions have included genital and anal pruritus, genital moniliasis, and vaginitis.

Administrotion ond Dosage: 'Ancef' may be administered intramuscularly or intravenously after reconstitution. See the package literature for reconstitution procedures.

See the package literature for dosoge recommendations.

How Supplied: 'Ancef' (sterile cefazolin sodium, SK&F)—supplied in vials equivalent to 250 mg., 500 mg. or 1 gram of cefazolin; in "Piggyback" Vials for intravenous admixture equivalent to 500 mg. or 1 gram of cefazolin; and in Pharmacy Bulk Vials equivalent to 5 grams or 10 grams of cefazolin.

ANCEF® IV IM

brand of sterile

CEFAZOLIN SODIUM

(LYOPHILIZED)

Injection: 250 mg., 500 mg. and 1 gram vials

Smith Kline & French Laboratories
Philadelphia, Pa.

SK&F
a SmithKline company

George W. Boerstler, M.B. (1792-1871) First President of the Ohio State Medical Society (Association)

Chester P. Swett, M.D.

THE FIRST PRESIDENT of the Ohio State Medical Society (1847), George Washington Boerstler, was the son of Dr. Christian and Dorothea Boerstler who emigrated to America from Germany in 1784. His grandfather, Jacob, was firmly established as a self-educated physician *(praktischer-Artz)* in the Village of Munchweiler, a town on the left bank of the Rhine River. Inasmuch as there was no other doctor in the area, Christian had obtained permission to practice medicine of sorts in Germany, after an apprenticeship to his father, Jacob.

Christian Boerstler and his family emigrated to Baltimore, Maryland with a group of 180 adults and their children, landing on September 22, 1784, after an eight-week-and-3-day journey fraught with political hazards, attempted slave impressment, storms, and sickness, from Rotterdam in the Netherlands. Baltimore was such an expensive city that the Boerstlers traveled on to Little Antietam Creek, about 80 miles from Baltimore and 12 miles south of Hagerstown. The next spring, they moved to Jerusalem, Maryland, later called Funkstown.

The New Homeland

Within two years, Dr. Boerstler had built a small house for his family and was an active participant in the community's progress. He was a doctor, a teacher, and served as a part-time preacher at the Old Lutheran Church. The volume of his medical practice increased to the extent that he built a larger home. His faith in the value of inoculation for smallpox was such that, in a two-year period, he had performed this procedure on 70 children including his own. By 1801, he had inoculated 1,050 patients, and only three of them had died.

Christian Boerstler was thrifty and frugal; besides practicing medicine, he served as a teacher and a Lutheran minister. He owned a powder mill and a Negro slave to help at the mill. He also dealt in real estate with resultant losses as well as profits, but he eventually gained some degree of financial security. At his death in 1833, his estate was appraised at $33,000 including 12 houses in Funkstown. He also was a newspaper columnist. For 12 years, he wrote a column for *The Hagerstown Calendar* entitled "Der Alt Volks-Friend."

George Washington Boerstler

Dr. Christian Boerstler's youngest son, George, was born October 18, 1792 in Funkstown. When George was very young, his father noted the boy's quick, keen mind and excellent intellect and planned for him to study for the Lutheran ministry. George received a good, basic education and reluctantly began to study theology. He soon informed his father of his dislike for that calling and of his desire to study medicine.

Sometime in early manhood, probably before the War of 1812, George traveled on horseback to Bethel, Clermont County, Ohio to marry Elizabeth Sinks. The Sinks family had resided in Boonesboro and/or Funkstown, before moving to Ohio. Clermont County is adjacent to and east of Hamilton County and Cincinnati; the Ohio River is the southern boundary of both counties.

Zane's Trace was the main road from Wheeling, Virginia to Limestone (Maysville), Kentucky. It passed within 30 miles of Bethel, Ohio. Undoubtedly, George

Presented in part, under the title, "The Family Origins and Career of Dr. George W. Boerstler, M.B.," at the Annual Meeting of the Ohio Academy of Medical History, held in Columbus, Ohio on May 7, 1977.

Dr. Swett is retired and resides in Lancaster, Ohio.

Submitted September 27, 1977.

*In this certificate, the surname was spelled Boerstler, Prior to this, the name was spelled Borestler; and it is so spelled on Dr. Christian's monument in Funkstown. Dr. George always spelled his name Boerstler after arriving in Ohio.

traveled over the Trace to reach Bethel; this road also passed through Lancaster, Ohio.

George evidently was deeply in love with the young lady or he would not have traveled for more than 400 miles one way, over mountains, to marry her. They returned to Funkstown, where he studied with his father.

Medical Education

George served in the War of 1812, first as a lieutenant, then promoted to adjutant, and later as a regimental paymaster. When the war ended, he received his discharge and returned to Funkstown.

His activities during the next three years are not documented, but it is likely that he studied medicine and other subjects to broaden his education. His father secured his admission to the University of Maryland for a course that may have covered two school terms. In March 1820, he received a bachelor's degree in medicine, at which time Nathan Potter, Professor of Theory and Practice of Medicine, presented him with a very flattering and laudatory certificate of introduction to medical men and medical societies in the United States.*

The young doctor first practiced in Boonesboro and a few years later in Funkstown. A militia company called the (Jaeger) "Yager Riflemen" was organized in Funkstown in 1821, and George was elected captain. Prior to his father's death on March 4, 1833, George moved to Hagerstown to practice.

The Boerstlers had two daughters, one who married Dr. Tom O. Edwards, probably after the move to Hagerstown. The second daughter, Estella Charlotte, was born in 1815 and died in 1846; she never was married.

Move to Ohio

Prior to his father's death, George and his family (including Dr. Edwards) had discussed plans to move to Lancaster, Ohio. George and his wife had pleasant memories of the thriving pioneer town where they had stopped enroute to and from Bethel, Ohio. Thus, after the estate of Dr. Christian was settled in 1834, the Boerstler and Edwards families began their move to the Buckeye State. They probably passed through Cumberland, on to Wheeling, thence by Zane's Trace to Lancaster, a town of about 6,000 population.

The two doctors obtained living quarters and opened offices in partnership, an amicable arrangement that continued as long as Dr. Edwards resided in Lancaster. In December 1835, Dr. Robert McNeill died at the height of his medical career in Lancaster, and his patients sought the professional attention of Doctors Boerstler and Edwards.

These doctors became solid and enterprising citizens and community leaders. Dr. Boerstler was active in local civic and political matters. When General Andrew Jackson died in 1845, Dr. Boerstler was the Chief Marshall at the local obsequies held for the former President. The same year, he gave a patriotic address to the Fairfield County Militia before they left for the Mexican War. In 1851, he traveled to Cincinnati and delivered an address in German at a reception for the Hungarian patriot, Louis Kossuth.

Dr. Beorstler was a member of the Whig Party and a pro-slave advocate, but he later became a Democrat and made political speeches. Dr. Edwards became a power in politics; he served one term in Congress, 1848-1849.

Dr. Boerstler's wife died in 1838, and he married Elizabeth Schur on November 21, 1839. Three daughters and one son were born to this union. The son was George Washington Boerstler, Jr., who graduated from Wooster College, studied medicine, and practiced in Lancaster until his death in 1916.

Interest in Medical Organizations

Dr. Boerstler became interested in medical organizations, attending medical meetings in Columbus and elsewhere in the state, making many acquaintances and cultivating friendships with medical men in Ohio. His talents, intellect, and leadership were recognized.

In early 1846, some medical leaders in Ohio announced a meeting to be held in Columbus in May, to organize a state medical society. Doctors from Fairfield County (Lancaster) attending that assembly were: J. M. Bigelow, M. Z. Kreider, George J. Sachse, and George W. Boerstler.

In records written in script, Dr. Boerstler's residence was erroneously marked as Findlay, Ohio. It is a well-known fact that doctors' penmanship is not always of a high grade. So, for a doctor who, as a secretary, scribbled minutes of a meeting in script, Fairfield could easily have been read as Findlay. Dr. Boerstler never changed his residence from Lancaster; his professional, civic, and political activities there are recorded many times.

President of the Ohio State Medical Society (Association)

On May 14, 1846, a group of doctors met in the Neil House Hotel in Columbus. Dr. George W. Boerstler was selected as chairman. He presided over the meeting, at which time the Ohio State Medical Society was established. He served as its president the first year, and in 1851, was elected to the presidency again, a tribute to his capabilities and inspirational leadership.

Dr. Boerstler continued to practice in Lancaster on a solo basis. (Dr. Edwards moved to Cincinnati after he served in Congress.) He experienced no major disabilities and practiced up to the day of his death. He dropped dead, presumably from a cardiac arrest, on October 10, 1871, eight days before his 79th birthday. He was mourned by the entire community, his many friends, and his patients. He possessed a genial and happy temperment punctuated with habitual courtesy and personal charm. The impact of his personality lingered long in the memories of his associates. He was blessed with all the virtues that adorn the character of a man of integrity.

Remarks to Shareholders

Physicians Insurance Company of Ohio
Annual Meeting
April 11, 1978

George N. Bates, M.D.

The achievements of the Physicians Insurance Company of Ohio (PICO) during its first year of business proved the soundness of the OSMA's decision to form a stock insurance company to serve the insurance needs of OSMA members. Premiums written during the year (1977) for medical professional liability insurance totaled $17 million. Approximately 25% of the OSMA membership now has this valuable and essential insurance protection through PICO's very comprehensive and competitively priced plan.

Despite the costs inherent in starting up an insurance operation, PICO recorded a modest net profit of $12,000. More importantly, PICO concluded its first year in a strong financial position. At December 31, 1977, policyholders' surplus totaled $7 million and assets amounted to nearly $25 million. Claims reserves were more than $9 million.

PICO already has met its primary objective, which was to meet an urgent need in Ohio for a readily available source of fairly-priced, broad coverage medical professional liability insurance.

PICO's board of directors and management responded to the company's initial marketing and financial progress by taking major steps to strengthen the company's growth and profit potential. The company added alternative primary professional liability coverage limits of $200,000 and $600,000 to its initial package of $100,000 and $300,000, and introduced occurrence excess coverage of $1 million.

PICO is one of only a handful of medical insurers that offer two choices of primary limits and excess coverage to physicians in all risk classifications, subject, of course, to eligibility and underwriting requirements.

The company eliminated the additional charge for partnership or partnership primary coverage, if all members of the entity have primary coverage with PICO. This protection traditionally has been provided for a charge equal to 20% of the primary coverage premiums for members of the entity. Thus, PICO's action resulted in very substantial savings, in most instances.

PICO's occurrence excess coverage of $1 million was made available to members of the OSMA who have primary limits of $200,000 and $600,000 with another approved insurer, subject to eligibility and underwriting requirements. This unusual marketing approach was taken because many OSMA members previously were unable to obtain occurrence excess coverage without paying large surcharges.

PICO introduced a complete line of property and casualty coverages. A specially designed Office Protection Policy, when written in conjunction with the company's professional liability plan, gives physicians near total protection for the conduct of their medical practice. PICO is one of the few insurers who offers both medical practice liability and medical premises liability, which avoids potentially costly and time-consuming litigation over disputable claims. PICO's homeowner's, family automobile, and other property and casualty products give physicians protection on their business and personal property.

During its first year of sales, PICO received many inquiries from Ohio physicians and surgeons about whether the company also intended to offer life and accident insurance. This interest resulted in shareholder approval, on March 2, 1978, of the formation of PICO Life Insurance Company as a subsidiary. PICO Life should be in operation by the middle of this year.

The story of PICO's success has spread rapidly throughout the medical profession. Physician's associations in other states have expressed interest in our organization's concepts. Several have asked for our assistance in making professional liability insurance available to their members.

Our first geographic expansion step has been taken with the completion of an agreement with the Kentucky Medical Association (KMA), under which we will offer professional liability insurance to physicians throughout that state with the support of the KMA. An insurance sales agency, through which our plan will be marketed, has been established. Sales are expected to be underway by this summer.

All of the actions I have just described were taken to strengthen and enhance the financial position and resources of our company and to increase its marketing potential.

Our primary objective has been and will remain meeting the insurance needs of members of the OSMA, principally, medical professional liability coverage. This objective will be accomplished most effectively by building a financially sound, aggresive, profitable, and diversified insurance organization. Accordingly, we have already begun the careful, selective program of product and geographic expansion I have outlined today.

Dr. Bates, Toledo, Chairman of the Board of Physicians Insurance Company of Ohio and Immediate Past President of the Ohio State Medical Association.

The computer data system developed exclusively for the physician.

Designed exclusively for the kind of physician who could use at least 25 hours in every day, 8 days a week, 53 weeks a year. The kind of physician who recognizes the value of efficiency in everything from speed reading to a skilled head nurse. Because that's the kind of physician who knows that a more efficient practice is the key to more efficient patient care.

And that's what we're all about.

The Physician's Computer Data System is pre-programmed exclusively to handle the physician's needs. Needs such as: insurance forms, patient records, billing, and other ledger information. And all of it in a fraction of the time it takes a person to do it.

But just about any person can be taught to operate it. Anyone that you choose from your staff will be trained at the same time we install the System and feed it your files and records.

They won't have to learn any special "computer talk" either. Because the Physician's Computer Data System is programmed in the same plain language as we're using here. Even the three component parts which make up the System are called quite plainly: the Computer, the Printer, and the Terminal.

And the Physician's Computer Data System will slip as easily into your budget as it does your everyday office procedure and staff makeup. With a leasing program of just $385 a month. (That includes installation and training.)

So maybe we can't give you that 25th hour a day. But with the Physician's Computer Data System, you get just a little more out of 24.

Send for complete details:
Microtech, Inc., 1127 S. Sixth St., Louisville, Kentucky 40203,
(502) 587-8099

The next best thing to a 25-hour day.



THE PHYSICIAN'S COMPUTER DATA SYSTEM,
by MICROTECH.

COLBY PROCLAIMS WOMAN SUFFRAGE

Signs Certificate of Ratification at His Home Without Women Witnesses.

MILITANTS VEXED AT PRIVACY.

Wanted Movies of Ceremony, But Both Factions Are

WASHINGTON, Aug. 26, 1920—



Social Security Bill Is Signed; Gives Pensions to Aged, Jobl

Roosevelt Approves Message Intended to Benefit 30,00 Persons When States Adopt Cooperating Laws—He C the Measure 'Cornerstone' of His Economic Progra

WASHINGTON, Aug. 14, The Social Security Bill, pro a broad program of unemplo insurance and old age pe and counted upon to benefi 20,000,000 persons, became l day when it was signed by dent Roosevelt in the prese those chiefly responsible fo ting it through Congress.

Mr. Roosevelt called the m "the cornerstone in a str which is being [illegible] mea[illegible] comple[illegible]

CO

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today, 94 to 0, and sent to

TRUMAN CLOSES TED NATIONS CONFEREN ITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary session

SIGN

the Draf Ends No

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the Secretary of the Army that



PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA
THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION
1155 FIFTEENTH ST. N. W. WASHINGTON, D. C. 20005

OHIO STATE MEDICAL ASSOCIATION

Imperial Europe Adventure

AUSTRIA – HUNGARY – YUGOSLAVIA

An eleven-day Luxury Holiday to the Europe of the Beautiful Blue Danube and Dalmatian Coast.

VIENNA *... City of Dreams and Waltzes. Shop along the Kartnerstrasse. Sample schnitzel and Sachertorte. See emerald Alpine meadows or imperial palaces.*

BUDAPEST *... Wine, Women and Gypsy Violins. Live as the aristocrats did – dine on magnificent goulash and drink "Bull's Blood Wine" to the strains of soulful violins. Wander through the cafe lined streets of the twin cities of Buda and Pest or cruise down the River Danube.*

DUBROVNIK *... The Riviera of the Dalmatian Coast. Relive history in the ancient walled city amidst churches, palaces and restaurants. Wander the "Placa" and discover peasant handicraft bargains. See magnificent Kotor Fjord and the ancient island village of Sveti Stefan.*

A remarkable journey full of European elegance and Bohemian atmosphere.

We depart Columbus on August 21, 1978 $1198

Send to: Ohio State Medical Association
600 South High Street
Columbus, Ohio 43215

Enclosed is my check for $ _____ $100 per person as deposit.

Names _____

Address _____

City _____ *State* _____ *Zip* _____

Space Strictly Limited – Make Reservations Now

A Non-Regimented **INTRAV** Deluxe Adventure



The Ohio State Medical Association Continuing Education Programs

Editor's Note: *The following are Category I courses offered in Ohio. Items for this listing come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in dates, places, or time occur too late to be corrected before publication. Physicians interested in a course are urged to contact the sponsoring organization to confirm the information listed. Sponsoring organizations may list Category I courses by contacting the OSMA Department of Continuing Medical Education or The Journal. Notification 90 days prior to the course would be appreciated. Due to space limitations, announcements may be published only once.* **See previous issues of The Journal for additional courses.**—*L.A.J.*

May 1978

EIGHTH ANNUAL RADIOLOGICAL SEMINAR: May 12-13, Veterans Administration Hospital, Dayton; sponsor: Veterans Administration Center, Dayton; 12 credit hours; contact: Emil Gutman, M.D., Program Director, Veterans Administration Center, 4100 West Third Street, Dayton 45428. (Preregistration required.)

INDUSTRY-RELATED DISEASES IN YOUR PRACTICE: May 17, Sheraton Dayton Downtown, Dayton; 7 credit hours; fee: $25; contact: Arlene L. Polster, Program Coordinator, Wright State University School of Medicine, P.O. Box 927, Dayton 45401, phone: 513/372-7140.

SURGICAL COMPLICATIONS—PART I: May 18, 8 AM, St. Elizabeth Hospital Medical Center, Youngstown; 4 credit hours; contact: Rashid A. Abdu, M.D., Director of Education, St. Elizabeth Hospital Medical Center, Belmont and Park Avenues, Youngstown 44501, phone: 216/746-7211, ext. 202.

CURRENT CONCEPTS IN ORTHOPEDIC SURGERY: May 18-19; The Cleveland Clinic Foundation, Cleveland; 12 credit hours; fee: $125, $65 students; contact: Center for CME, The Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

ADVANCES IN FETAL MONITORING— UPDATE 1978: May 24, Cleveland Metropolitan General Hospital, Cleveland; sponsor: Cleveland Metropolitan General Hospital; cosponsor: Case Western Reserve University; 7 credit hours; contact: M. Rosen, M.D., Department of Obstetrics and Gynecology, Cleveland Metropolitan General Hospital, 3395 Scranton Road, Cleveland 44109, phone: 216/398-6000.

OPTIMAL USE OF THE LABORATORY— A GUIDE FOR THE CLINICIAN: May 24, 8 AM-5 PM; Lutheran Medical Center, Cleveland; 6 credit hours; fee: $50; contact: Lutheran Medical Center, Office of Continuing Medical Education, 2609 Franklin Blvd. Cleveland 44113, phone: 216/696-4300, Ext. 329.

June 1978

INTERNAL MEDICINE: RECENT ADVANCES IN DIAGNOSIS AND TREATMENT: June 5-9, Cincinnati; sponsor: American College of Physicians; cosponsor: University of Cincinnati Medical Center; 34 ¾ credit hours; contact: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104, phone: 215/243-1200.

MINI-RESIDENCY IN OCCUPATIONAL MEDICINE: June 5-June 23; University of Cincinnati College of Medicine; 90 credit hours; contact: Sidney Lerner, M.D., Division of Clinical Studies, Dept. of Environmental Health, University of Cincinnati, College of Medicine, Cincinnati 45267, phone: 513/872-5284.

FAMILY MEDICINE REVIEW: June 12-16, Columbus Hilton Inn, Columbus; sponsor: Ohio Academy of Family Physicians; 40 credit hours; fee: $250; contact: Mrs. Florence I. Landis, Executive Director, Ohio Academy of Family Physicians, 4075 North High Street, Columbus 43214, phone: 614/267-7867.

Journal Advertisers

American Medical Association.....319
Breon Laboratories, Inc.....286
Brown Pharmaceutical Company, Inc. 328, 334, 335
Burroughs Wellcome Co.....336, 337
Daniels-Head & Associates, Inc.....293
Eli Lilly and Company.....331
Immke Circle Leasing.....290
INTRAV 314
Mead Johnson.....323, 324, 325, 326
Medical Protective Company.....330
Menendian Carpets.....333
Microtech, Inc.....311
Nationwide Insurance.....343
Ohio Medical Indemnity.....338
Pharmaceutical Manufacturers Association 312, 313
Physicians Insurance Company of Ohio, Inc.....318
Practice Productivity, Inc.....305
Roche Laboratories, Div. of Hoffmann-LaRoche, Inc. .....302, 303, Cover 2, Cover 3, Cover 4
Schmidt's Sausage Haus.....330
Smith, Kline and French Labs.....306, 307
Turner and Shepard, Inc.....341
United States Air Force.....332
United States Navy.....285
Upjohn Pharmaceutical Company.....344
Warren-Teed Laboratories.....298, 299, 317
Wendt-Bristol Company.....291, 342
Windsor Hospital.....339

Ohio Medical Indemnity Medical Necessity Program

D. Tom Dwyer

Physicians and insurers share a dilemma— finding ways to maintain and to increase high standards of medical care that advanced technologies have made possible and yet assuring control of cost increases. Although medical efficacy is, and will always be, the primary consideration in choosing a treatment mode, the day is past when it can be the sole consideration. Today's increasing demand for medical services coupled with spiraling costs for the services have added an additional consideration— how the cost of the treatment relates to its medical efficacy.

Because of their interest in a stable and vigorous health care economy, physicians and health insurers must assume a major role in working out innovative solutions to these complex problems. Individual as well as joint efforts will be necessary, with each group working within the limits of the natural division of responsibility inherent in the "quality care and reasonable cost" balance. Both must serve as educators of the public since consumers are also affected by medical and insurance-premium cost increases.

Because of the complexity of the issues facing the health economy today, we all recognize that no single solution— or simple— will emerge. Rather, there will be many workable solutions; and they will come through public imperative as well as private initiative. Most of us who work in the health care field— as providers or as payers— also would agree that private initiative is the best way to arrive at solutions workable for all of us, provider, payer, and consumer.

It was a desire to find workable solutions to health cost problems and to move toward that all-important balance of quality care and reasonable cost that led to the development of the Blue Shield Medical Necessity Program. This program is the result of a year-long study by representatives of the Blue Shield Association (BSA) and national physicians' specialty societies. The goal of the program is to discourage use of outmoded or ineffective diagnostic or surgical procedures which add to the cost of health care without offering equivalent benefits to patients.

Officials of the American College of Physicians, American College of Radiology, and American College of Surgeons reviewed diagnostic and surgical procedures, each society reviewing those within its own specialty. They identified procedures considered of questionable value and applicable to one or more of the following categories: (1) new procedures of unproven value; (2) established procedures of questionable usefulness; (3) procedures which are redundant when performed in combination with other procedures; and (4) diagnostic procedures which do not add information when repeatedly performed for the same condition.

Procedures which the specialty groups identified as meeting those criteria became the nucleus of the Medical Necessity Program. As time goes on and as medical technology progresses, additional procedures will be included when they are replaced by more advanced or more effective methods. Once the initial group of questionable procedures had been identified, BSA and the specialty societies recommended that local Blue Shield plans stop routine payment for these services. Instead, plans were advised to offer case-by-case review of each claim, paying only for those which included clear, documented evidence of medical necessity. The precise methods which each plan would use in implementing the program were left to individual plans, all of whom are autonomous corporations.

Local Implementation

In the year since the announcement by BSA and the specialty groups of the formation of the program (May 1977), Ohio Medical Indemnity (OMI) has been preparing for its participation in the national program. Internally, we have reviewed our plan's data on the procedures in question and have developed a computerized system for "flagging" such claims for individual review. Externally, and of equal importance, we have conferred with professional medical groups in Ohio to explain the program, to share concerns about its concepts and intent, and to solicit their expert counsel in the medical aspects of the program.

Expert Medical Advice

OSMA support was solicited by OMI in the design and implementation of the program. Support is being furnished through the establishment of a special medical advisory committee composed of representatives of various medical specialties. This advisory committee will have the responsibility of reviewing each procedure suggested by the national societies before it is included in OMI's Medical Necessity Program. Committee members will be drawn from these areas of specialty: cardiology or cardiovascular surgery, general surgery, neurology, family medicine, obstetrics and gynecology, internal medicine, radiology, and urology.

We hope to have the support of the medical commu-

Mr. Dwyer, Columbus, Director, Provider Affairs, Ohio Medical Indemnity, Inc.

nity in Ohio for this important program. Only by working together can medical professionals and health insurers assure Ohioans of the highest standards in medical and surgical care— at reasonable cost.

Procedures Recommended for Individual Review

Specialty societies recommend that Blue Shield pay for the following procedures only when claims for the services are accompanied by documentation of medical necessity. This initial list (as suggested by the national associations) is being reviewed by OMI and the OSMA medical advisory group; it will be specifically adapted to meet local needs. In addition, the list of procedures will be updated continuously. The Council of Medical Specialty Societies (CMSS), comprising 20 such societies, will review and refer to the appropriate component society questions about procedures which may meet the criteria for program inclusion.

SURGICAL PROCEDURES

*Ligation of internal mammary arteries, unilateral or bilateral
*Radical hemorrhoidectomy, Whitehead type
*Omentopexy for establishing collateral circulation in portal obstruction
*Kidney decapsulation, unilateral and bilateral
*Perirenal insufflation
*Nephropexy fixation or suspension of kidney (independent procedure), unilateral
*Circumcision, female
*Hysterotomy, nonobstetrical, vaginal
*Supracervical hysterectomy: subtotal hysterectomy, with or without tubes and/or ovaries, one or both
*Uterine suspension
*Uterine suspension with presacral sympathectomy
*Hypogastric or presacral neurectomy (independent procedure)
*Fascia lata by stripper (when used to treat lower back pain)
*Fascia lata by incision and area exposure, with removal of sheet (when used to treat lower back pain)
*Ligation of femoral vein, unilateral and bilateral (when used to treat postphlebitic syndrome)
*Excision of carotid body tumor with or without excising carotid artery (when used to treat asthma)
*Sympathectomy, thoracolumbar, unilateral or bilateral (when used to treat hypertension)
*Sympathectomy, lumbar, unilateral or bilateral (when used to treat hypertension)
*Splanchnicectomy, unilateral and bilateral (when used as treatment for hypertension)
*Ligation of thyroid arteries (independent procedure)
*Fabric wrapping for abdominal aneurysm (considered a procedure of unproven value)
*Extra-intracranial arterial bypass for stroke (considered of unproven value)

DIAGNOSTIC PROCEDURES

*Basal metabolic rate (BMR)
*Protein bound iodine (PBI)
*Icterus index
*Ballistocardiogram (BCG)
*Phonocardiogram with interpretation and report and with indirect carotid artery tracing or a similar study
*Angiocardiography using carbon dioxide, supervision and interpretation only
*Angiography extremity unilateral, supervision and interpretation only, single view unless in an emergency
*Bronchoscopy, with injection of radioactive substance



SOME INSURANCE COMPANIES MAY COME AND GO BUT PICO IS HERE TO STAY

Not long ago, some insurance companies serving Ohio physicians met the malpractice insurance dilemma with decisive action. They dropped some policyholders, increased premiums for others, established lower liability limits or refused to write new policies.

PICO helped fill the void and, in the process, proved that Ohio physicians could enjoy the benefit of adequate professional liability protection, at a reasonable cost.

Now, some of those insurance companies that thought it couldn't be done are coming back to give it another try.

But while some insurance companies may come and go, Ohio physicians can take comfort in the knowledge that PICO is here to stay.



Physicians Insurance Company of Ohio
P.O. Box 27905
6100 Channingway Boulevard
Columbus, Ohio 43227

Telephone (Toll-Free) 1-800-282-7515 for the name of the authorized PICO representative in your area.

Lift the Quality of Medicine You Practice to A New High!



American Medical Association/127th Annual Convention
June 17-21, 1978/St. Louis

Continuing Medical Education Highlights!
The whole purpose of the AMA's CME program is to help you do what attracted you to medicine in the first place: provide the high quality care your patients need.

The scientific program is geared to help you do exactly that. Emphasis is on the *practical* aspects of new developments—clinical information of immediate use in your practice. Whether you're in primary care or a specialty, the large selection of courses allows you to focus on those areas in which you want to update your knowledge. The program features:

- 55 Category 1 Postgraduate Courses
- 30 Sessions, 20 Telecourses, 13 Clinical Dialogues, 3 Motion Picture Seminars — all Category 1 and FREE OF CHARGE
- 100 Scientific and 125 Industrial Exhibits
- 3 AMA Auxiliary Sessions (no credit)

The New Spirit of St. Louis!
New convention center. New hotels. New attractions. There's a whole new look and spirit in St. Louis today. With lots of things to do and see. Soar to the top of the nation's tallest monument, the Gateway Arch. . .beat your feet to rollicking ragtimers aboard a showboat. . .dine on gourmet French cuisine whose recipes came up the river from New Orleans. . .visit the hospitality room of the world's largest brewer. The new Spirit of St. Louis is yours to enjoy at the 127th AMA Annual Convention.

PLAN NOW TO ATTEND
For complete information, return this coupon today.

Dept. of Meeting Services
American Medical Association
535 N. Dearborn/Chicago, IL 60610

Please send me complete information on the 127th AMA Annual Convention in St. Louis as soon as it becomes available.

Name_____

Address_____

City/State/Zip _____










BEN
CAETH





OSMA Auxiliary "Day at the Legislature"

Photographs by Linda A. Porterfield





ROW 1 (across): (1) Sen. Kinsey Millerson, Freeport; (2) Sen. Stanley J. Aronoff, Cincinnati; (3) Richard Murray, Clerk of the House, Columbus, and Rep. Barney Quilter, Speaker Pro Tempore, Toledo. *ROW 2 (across):* (1) Rep. Helen H. Fix, Cincinnati; (2) Rep. Larry H. Christman, Englewood; (3) William Paul, M.D., and Rep. Phale D. Hale, Columbus; (4) Rep. James L. Baumann, Columbus. *ROW 3 (across):* (1) Sen. M. Ben Gaeth, Defiance; (2) Rep. Terry M. Tranter, Cincinnati; (3) D. Brent Mulgrew, J.D., OSMA Director of State Legislation, and Sen. Oliver Ocasek, President Pro Tempore, Northfield; (4) Rep. Norman A. Murdock, Cincinnati, and Richard A. Ayish, OSMA Ass't. Director of State Legislation.





THE OHIO STATE Medical Association

Proceedings of the Council

A regular meeting of the Council of the Ohio State Medical Association was held Saturday, April 1, 1978 at the OSMA Headquarters' Office, 600 S. High Street, Columbus, Ohio.

ATTENDANCE

OSMA Council present: William M. Wells, M.D., Newark, President; John J. Gaughan, M.D., Cleveland, President-Elect; George N. Bates, M.D., Toledo, Past President; Robert G. Thomas, M.D., Elyria, Secretary-Treasurer; Stewart B. Dunsker, M.D., Cincinnati, First District Councilor; W. J. Lewis, M.D., Dayton, Second District Councilor; Alford C. Diller, M.D., Convoy, Third District Councilor; C. Douglass Ford, M.D., Toledo, Fourth District Councilor; C. Edward Pichette, M.D., Youngstown, Sixth District Councilor; Robert E. Rinderknecht, M.D., Dover, Seventh District Councilor; Richard E. Hartle, M.D., Lancaster, Eighth District Councilor; Thomas W. Morgan, M.D., Gallipolis, Ninth District Councilor; J. Hutchison Williams, M.D., Columbus, Tenth District Councilor; S. Baird Pfahl, Jr., M.D., Sandusky, Eleventh District Councilor; and William Dorner, Jr., M.D., Akron, Twelfth District Councilor.

Absent: Theodore J. Castele, M.D., Cleveland, Fifth District Councilor.

Ohio Delegation to the AMA present: John E. Albers, M.D., Cincinnati; Oscar W. Clarke, M.D., Gallipolis; Richard L. Fulton, M.D., Columbus; Edward E. Grable, M.D., Canton; P. John Robechek, M.D., Cleveland; and Robert N. Smith, M.D., Toledo.

Guests present: John H. Ackerman, M.D., Columbus, Director, Ohio Department of Health; James E. Pohlman, Esq., Columbus, OSMA Legal Counsel; David L. Rader, Columbus, Vice President/Administration, PICO; and Mrs. Albert May, Marion, President, OSMA Auxiliary.

OSMA Staff present: Hart F. Page, Herbert E. Gillen, Jerry J. Campbell, Robert D. Clinger, Katherine E. Wisse, D. Brent Mulgrew, Gail E. Dodson, Becky Doll, Linda Porterfield, Rick Ayish, and David C. Torrens.

Dr. Wells opened the meeting with an expression of appreciation to all officers, councilors and staff for their support during the year. He personally thanked those whose terms on the Council expire in May— Dr. Bates, Dr. Morgan, and Dr. Rinderknecht— for their long service to the Association.

ADMINISTRATION DEPARTMENT

The February 11, 1978 minutes **were approved.**

Committee on Judicial and Professional Relations

Mr. Mulgrew reviewed the minutes of a meeting of the Committee on Judicial and Professional Relations, held March 29, 1978.

The Committee recommended the repeal of the existing OSMA statement and policy on "Yellow Page" listing of physicians and the adoption of a statement of the American Medical Association, dated March 21, 1978, in lieu thereof. The Council **approved** the recommendation.

The Committee reported its consideration of OSMA Resolution No. 28-77, with regard to physician advertising. The Committee recommended and the Council **approved** as OSMA policy the statement contained in Section 6.00 of the 1977 edition of AMA Judicial Council *Opinions and Reports.*

Regarding existing OSMA Multiphasic Health Testing Guidelines, the Committee recommended, and the Council **approved,** their repeal. It was noted that the Ohio State Medical Board publishes a set of guidelines on this subject.

The Committee recommended, and the Council **approved,** the repeal of existing guidelines with regard to the use of "bank cards" in the physician's office.

An inquiry with regard to services of a surgeon assistant was re-referred to the Medical Services Review Committee on request of the Committee.

The Committee recommended, and the Council **approved,** the proposed revision of the AMA Code of Ethics, now under consideration by the AMA House of Delegates.

The report as a whole **was approved.**

Committee Purposes and Objectives

A draft of proposed committee purposes and objectives was submitted for Council study and future consideration.

FINANCIAL AND MEMBERSHIP DEPARTMENT

Mrs. Wisse presented the membership report which indicated a gain of 249 members for the first quarter.

Auditing and Appropriations Committee

Dr. Rinderknecht presented the minutes of the March 31, 1978 meeting of the Auditing and Appropriations Committee.

The Council **approved** the Committee's progress report on a structure to provide additional services to specialty societies on a three-level basis.

Also **approved** by the Council was a Committee recommendation that dues for active and associate members be set at $170 and for life active members at $3,000.

The report as a whole was adopted, and at the conclusion of his presentation, Dr. Rinderknecht received

(continued on page 327)



Does it influence your choice of a peripheral/cerebral vasodilator*?

- Vasodilan—compatible with coexisting diseases
- Vasodilan—compatible with concomitant therapy
- Vasodilan—compatible with your total regimen for vascular insufficiency

*__Indications:__ Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily.

Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

U.S. Pat. No. 3,056,836

VASODILAN®
(ISOXSUPRINE HCl)
20-mg tablets

Mead Johnson PHARMACEUTICAL DIVISION

© 1978 MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA 47721 U.S.A. MJL7-4268

This asthmatic isn't worried about his



next breath...

he's active
he's effectively
maintained on

QUIBRON®

Each capsule or tablespaanful (15 ml) elixir cantains theaphylline (anhydraus) 150 mg and glyceryl guaiacalate (guaifenesin) 90 mg. Elixir: alcohal 15%

high theophylline for effective around-the-clock therapy

Quibron may give the asthmatic up to eight hours of bronchodilation with each dose and provides the high dosages of theophylline which are now believed necessary to keep patients free of acute attacks and chronic wheezing.

100% free theophylline

Quibron helps achieve high serum theophylline levels with minimal dosage volume...delivers 100% free theophylline in comparison to many other compounds which contain from 47% to 91% effective theophylline.

individualized theophylline dosage schedule

Today's more efficient usage of theophylline includes individualizing dosage and monitoring serum theophylline levels. The usual recommended dosages of Quibron are: Adults—1 to 2 capsules or tablespoonfuls every 6 to 8 hours; dosage may be cautiously adjusted upward when necessary to a maximum of 2000 mg theophylline per 24 hours. Children under 12—4 to 6 mg theophylline per kg/body weight every 6 to 8 hours; dosage may be cautiously adjusted up to 9 or 10 mg/kg every 6 hours.

Now, for the asthmatic who requires high-dose theophylline therapy for therapeutic serum concentrations

Mead Johnson Pharmaceutical Division announces

QUIBRON®-300

Each capsule cantains 300 mg theaphylline (anhydraus) and 180 mg glyceryl guaiacalate (guaifenesin)

For Brief Summary, please see the last page of this advertisement.

QUIBRON®-300

Each capsule contains 300 mg theophylline (anhydrous) and 180 mg glyceryl guaiacolate (guaifenesin)

The new high-dose theophylline capsule... for dependable theophylline therapy when products of lower dosage do not adequately control asthma symptoms.

Specially formulated

...for optimal efficacy

Quibron-300 is appropriate therapy for asthma patients whose symptoms are not adequately controlled on lower doses of theophylline, particularly for patients whose theophylline dosage has been adjusted upward to achieve therapeutic serum levels. In one study,[1] an average peak increase in FEV_1 of 35% was demonstrated after a single dose equivalent to one Quibron-300 capsule, and significant improvement in this pulmonary function lasted for nearly eight hours after administration.

...for optimal predictability

One Quibron-300 capsule q6-8h yields therapeutic serum levels (10-20 mcg/ml) in many adults. With a single dose, more than 75% of patients achieved serum levels potentially providing clinical benefit (5-15 mcg/ml). Half-life of theophylline varies widely from patient to patient, making monitoring of theophylline therapy important. Patient response may be monitored clinically if blood levels are not available as long as dosage does not exceed 1200 mg in 24 hours for adults.

...for optimal dosage convenience

The simple, convenient dosage of new Quibron-300—one capsule every six to eight hours—makes it easy for patients to comply with high-dose regimens often required to achieve therapeutic serum levels. Quibron-300 capsules may provide maximum therapeutic value with maximum convenience. In fact, the switch from a low-dose to a high-dose regimen may be accomplished by merely switching capsules, by stepping up to Quibron-300 capsules.

...for minimal theophylline side effects

Adverse reactions to theophylline are related to serum levels and are usually not a problem at concentrations below 20 mcg/ml. Of 45 patients studied[1] after a single dose, only seven reported adverse reactions. The most common reaction was a feeling of lightheadedness by three of these seven patients.

Reference 1. Data on file. Mead Johnson Pharmaceutical Division.

Indications: For the symptomatic treatment of bronchospastic conditions such as bronchial asthma, asthmatic bronchitis, chronic bronchitis, and pulmonary emphysema.

Dosage: Quibron—Adults: 1-2 capsules or 1-2 tablespoonfuls elixir every 6-8 hours. Children under 12: 4-6 mg theophylline/kg body weight every 6-8 hours.

Quibron-300— Adults: 1 capsule every 6-8 hours.

Theophylline dosage may be cautiously increased to 2000 mg/24 hour in adults and 9 or 10 mg/kg every 6 hours in children. Monitoring of serum theophylline levels at higher dosages is recommended.

Precautions: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other xanthine derivatives concurrently. Use in case of pregnancy only when clearly needed.

Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 μg/ml.

How Supplied: Quibron Elixir: Bottles of 1 pint and 1 gallon. Quibron Capsules: Bottles of 100 and 1000 and unit-dose packs of 100. Quibron-300 Capsules: Bottles of 100.

Mead Johnson PHARMACEUTICAL DIVISION

© 1978 Mead Johnson & Company • Evansville, Indiana 47721 U.S.A.

MJL 7-4280

the applause and commendation of the Council for his two years as chairman of the Auditing and Appropriations Committee.

DEPARTMENT OF CONTINUING MEDICAL EDUCATION

Committee on Maternal and Neonatal Health

The minutes of the February 19, 1978 meeting of the Committee on Maternal and Neonatal Health were presented by Mrs. Dodson and **were approved.**

Workshops on Financial Control and Establishing Yourself in Medical Practice

Mr. Torrens reported on the four, half-day, March 7 through March 10, Financial Control Workshops and an Establishing Yourself in Medical Practice Workshop, March 14 and 15, both sponsored by OSMA. The Financial Control Workshops were held in Columbus, Dayton, Perrysburg, and Cleveland, and the Establishing Yourself Workshop was conducted at OSMA Headquarters in Columbus.

Committee on Emergency and Disaster Medical Care

The minutes of the March 18 meeting of the Committee on Emergency and Disaster Medical Care were presented by Mr. Torrens.

The Council **approved** a recommendation for endorsement of House Bill 1092 (Ohio General Assembly) to permit "Emergency Medical Technicians-Ambulance" to establish and maintain "intravenous infusions," providing the medical training is the same as a paramedic and is approved by the Ohio Board of Regents.

A suggested statement on "Emergency Medical Service and the Physician Outside the Hospital" was not approved, and it was the Council's opinion that this matter should be addressed informally at the local level.

The remainder of the report **was approved.**

Committee on Education

The minutes of the meetings of the Committee on Education, held February 15 and March 22, were presented by Mrs. Dodson and **were approved.**

GOVERNMENT MEDICAL CARE DEPARTMENT

Ohio Medical Indemnity, Inc.

Dr. Bates reported the nominating committee had recommended the following persons be nominated and elected to the OMI Board of Directors for the ensuing year: Ben Arnoff, M.D., Columbus; Dwight L. Becker, M.D., Lima; William T. Blair, Columbus; Lou J. Briggs, Worthington; Albert A. Brust, M.D., Dayton; Joseph D. Cionni, M.D., Cincinnati; Guerney H. Cole, Jr., Middletown; L. Eugene Duff, Lima; Milton M. Gatch, Owensville; Cecil Hampton, Columbus; Richard J. Hanley, Toledo; W. D. Henceroth, D.O., Grove City; James Jacobs, Cincinnati; Paul A. Jones, M.D., Zanesville; Martin R. Otto, Warren; James G. Roberts, M.D., Akron; Frank D. Robinson, Canton; Robert N. Smith, M.D., Toledo; William E. Sovik, M.D., Youngstown; Phillip W. Tefft, Columbus; and James F. Zeller, M.D., New Philadelphia.

By official action, the Council **approved** the nominations presented and authorized the following persons to cast the votes of the Ohio State Medical Association, a stockholder, at the annual stockholders' meeting, on April 19, 1978, including the election of directors placed in nomination by the Council at this meeting: William M. Wells, M.D., or John J. Gaughan, M.D., or William Dorner, Jr., M.D., or W. J. Lewis, M.D.

Blue Cross Advisory Committee

A letter dated February 8, 1978 from Blue Cross of Central Ohio asked the support of the OSMA in the former's proposal to reactivate its Medical Advisory Committee. Such committee would involve physicians from 29 county medical societies in the agency's service area.

The Council voted to support the proposal.

Committee on Cost Effectiveness

Dr. Pfahl, Mr. Gillen, and Ms. Doll discussed activities and plans of the Committee, which met February 12 and was scheduled to meet again April 2, 1978.

Committee on Membership and Planning

Mr. Gillen presented the minutes of the March 18, 1978 meeting of the Committee on Membership and Planning. The Council **approved** the minutes, including the implementation of an opinion survey of the membership.

A letter from the Madison County Medical Society regarding Professional Standards Review was received for information.

Mr. Gillen announced that the Health Planning Guidelines had been received and had been mailed to all Councilors.

DEPARTMENT OF ORGANIZATION SERVICES

AMA Delegation

Dr. Robechek reported on the meeting of Ohio's Delegation to the AMA, March 31, 1978.

He announced that the following officers of the delegation were recommended by the delegation: Chairman— Dr. Robechek, Vice Chairman— Dr. Clarke, Co-Chairman—Dr. Wells (automatic). The Council **voted approval** of the delegation's recommendation.

The Council **approved** the delegation's recommendation that Dr. Lewis be presented and supported as a candidate for election to the AMA Board of Trustees in June 1978, if he chooses to run for the office.

Dr. Robechek announced that Dr. Porterfield will serve as hospitality chairman; Dr. Hammon as resolutions chairman, and Dr. Fulton, elections and candidates chairman.

PICO

Mr. Rader discussed the newly published *Annual Report* of Physicians Insurance Company of Ohio.

The Council adopted the following resolution which was reviewed in advance by the Chairman of the OSMA Committee on Member Insurance Plans:

> WHEREAS, the Ohio State Medical Association in 1976 formed the Physicians Insurance Company of Ohio to

(continued on page 329)

When **impotence** *due to*

androgenic deficiency is driving them apart



Android®-5 Buccal Tabs
Android®-10 Oral Tabs
Android®-25 Oral Tabs

Methyltestosterone U.S.P. – 5, 10, 25 mg.

Additional Indications:
REPLACEMENT THERAPY. When Androgen Deficiency is cause of:

- Male Climacteric
- Eunuchoidism, Eunuchism
- Post-Puberal Cryptorchidism

New Double-Blind Study ANDROID-25 vs. Placebo*

*R. B. Greenblatt, M.D.; R. Witherington, M.D.,; I. B. Sipahioglu, M.D.; Hormones for Improved Sexuality in the Male and Female Climacteric. **Drug Therapy,** Sept. 1976.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE: Robert B. Greenblatt, M.D., and D. H. Perez, M.D.:** "The Menopausal Syndrome," *Problems of Libido in the Elderly,* pp. 95-101, Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

BROWN **THE BROWN PHARMACEUTICAL CO., INC.** 2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

Write for Reprints and Samples.

provide an insurance mechanism for professional liability and other types of insurance; and

WHEREAS, the Ohio State Medical Association has, for many years, sponsored various life, accident and health insurance plans for the benefit of OSMA members and their dependents and employees; and

WHEREAS, the Board of Directors of the Physicians Insurance Company of Ohio, with the cooperation and the encouragement of The Council of the Ohio State Medical Association, has recently formed PICO Life Insurance Company, a subsidiary of PICO, to offer life, accident and health insurance to members of the Ohio State Medical Association and others;

THEREFORE BE IT RESOLVED, that The Council of the Ohio State Medical Association hereby directs the administrators for its sponsored life, accident and health programs to utilize whenever possible the underwriting capacity of the PICO Life Insurance Company.

Dr. Wells, with Dr. Gaughan as alternate, was authorized by the Council to cast the vote of the OSMA, a stockholder, at the PICO Annual Meeting on April 11, 1978.

Mr. Campbell presented JUA statistics and reported on the Jeppesen-Sanderson (MED-PREP) program.

DEPARTMENT OF HEALTH EDUCATION

State Planning Committee

Mr. Clinger presented for information a report on the March 1, 1978 meeting of the State Planning Committee for Health Education in Ohio.

Committee on Mental Health

The minutes of the March 5, 1978 meeting of the Committee on Mental Health were presented by Mr. Clinger.

The Council voted to support the Committee's recommendation for support, in principle, of Uniform Alcoholism and Intoxication Treatment legislation.

A subcommittee on amendments to such proposal **was also approved.**

The minutes as a whole **were approved.**

DEPARTMENT OF FEDERAL LEGISLATION AND PUBLIC POLICY

Mr. Page presented Mr. Edgar's written report on a Washington Visitation February 21-22, 1978, involving four Ohio Congressmen who are on the House Committee on Interstate Commerce, their physician counterparts on the OSMA Committee on Federal Legislation and Messrs. Edgar and Page.

The visitation was held as an emergency in cooperation with the American Medical Association with regard to HR 10460, Congressman Rogers' bill to extend and amend Public Law 93-641, the Health Planning Law.

Mr. Edgar's report also discussed department efforts with regard to hospital cost containment legislation.

DEPARTMENT OF STATE LEGISLATION

Committee on Prisons and Jails

The minutes of the March 1, 1978 meeting of the Committee on Prisons and Jails were presented by Mr. Ayish for information.

Mr. Mulgrew presented an update report on the Optometry Bill, Medical Mutual's bill that limits a physician's right to sue a third-party payor, and the Certificate of Need Bill, in the Ohio General Assembly.

He announced that John Thompson's Health and Retirement Committee would hold hearings on health costs in (Columbus), Portsmouth, Cincinnati, Toledo, and Cleveland and that physicians should make their views known.

Mr. Ayish announced that HB 1092, to permit Emergency Medical Technicians-Ambulance to maintain "intravenous lifelines," had been amended as requested by the OSMA.

HB 1098— proposed changes to the Physician's Assistant law— was discussed. The Council voted to oppose the legislation.

With regard to a proposal by Governor Rhodes to encourage physicians to practice in rural areas, the Council expressed support in principle for concepts of this kind to encourage physicians to serve less-populated areas in the state.

COMMUNICATIONS DEPARTMENT

Ms. Doll discussed a series of P.R. Seminars being conducted by the OSMA Department of Communications.

OHIO STATE MEDICAL JOURNAL

Mrs. Porterfield presented a report on the annual meeting issue of *The Journal.*

COUNCILOR REPORTS

The Councilors reported on the activities in their districts and on dates for district caucuses.

OHIO DIRECTOR OF HEALTH

Dr. Ackerman presented a proposal for a Cooperative Health Statistics System to be operated by his department and asked the support of the OSMA in obtaining grant funds for its implementation.

The Council endorsed the program in principle.

CANCER SOCIETY COMMUNICATION

A proposal for an anti-smoking resolution from the Ohio Division, American Cancer Society, was received with appreciation.

CEREBELLAR STIMULATOR PACEMAKERS

A question with regard to cerebellar stimulator pacemakers was referred to the Ohio Neurosurgical Society for advice.

REQUEST FOR FINANCIAL ASSISTANCE

A request from the Mahoning County Medical Society for financial assistance in connection with its defense of a pending antitrust suit in Federal District Court in Cleveland was discussed.

(continued on next page)

It was the consensus of Council that the subject of financial assistance to component societies and members was becoming an increasingly significant issue for the Association and, accordingly, the Council voted to introduce an appropriate emergency resolution for consideration by the House of Delegates at the Annual Meeting in May.

AUXILIARY REPORT

Mrs. May, President of the Auxiliary, presented a report on the activities of and proposals from the Auxiliary. Dr. Wells congratulated her on her administration and for her dedication to the organization.

MEDICAL ASSISTANTS

A proposal summary "Coordination of Allied Health Programs in Ohio," an HEW-funded system for coordination of educational programs preparing allied health personnel, was brought up by Dr. Hartle and was referred to the Committee on Health Manpower.

NURSE COMMITTEE

A request from the Ohio Nurses Association for a conference committee on common issues and concerns of the OSMA and OSNA **was approved.** Dr. Wells appointed Dr. Williams as chairman for OSMA.

There being no further business, the meeting was adjourned.

ATTEST: Hart F. Page, CAE
Executive Director

★

Specialized Service
IN
PROFESSIONAL LIABILITY INSURANCE
is a high mark of distinction

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

OHIO OFFICES:
CINCINNATI: Room 700, 3333 Vine Street, (513) 751-0657, L. A. Floherty
CLEVELAND: Suite 106, 23360 Chogrin Boulevard, Beechwood 44122, (216) 464-9950
A. C. Spoth, Jr., R. A. Zimmermon
COLUMBUS: 1989 West 5th Ave., (614) 486-3939, J. E. Hansel
TOLEDO: 1011 Sandusky St., Suite H, P.O. Box 331, Perrysburg 43551, (419) 874-8080, R. E. Stallter

Schmidt's 1886 Sausage Haus
UND RESTAURANT
GERMAN VILLAGE COLUMBUS



Singalongs, German Band, Cocktails and Keg Beer. All meats, desserts, and soups are made right here in Schmidt's immaculate kitchens. Ask to see. Buy Bratwurst and Bahama Mamas to take home. 4 blocks East of S. High St. on Kossuth, just a few blocks from your medical association headquarters.
Fantastic new private party and meeting rooms serving German Buffet or any size sizzling Top Grade steak dinners. Reservations taken for parties 35 and up. Call 444-5050.

Liveliest Spot In German Village

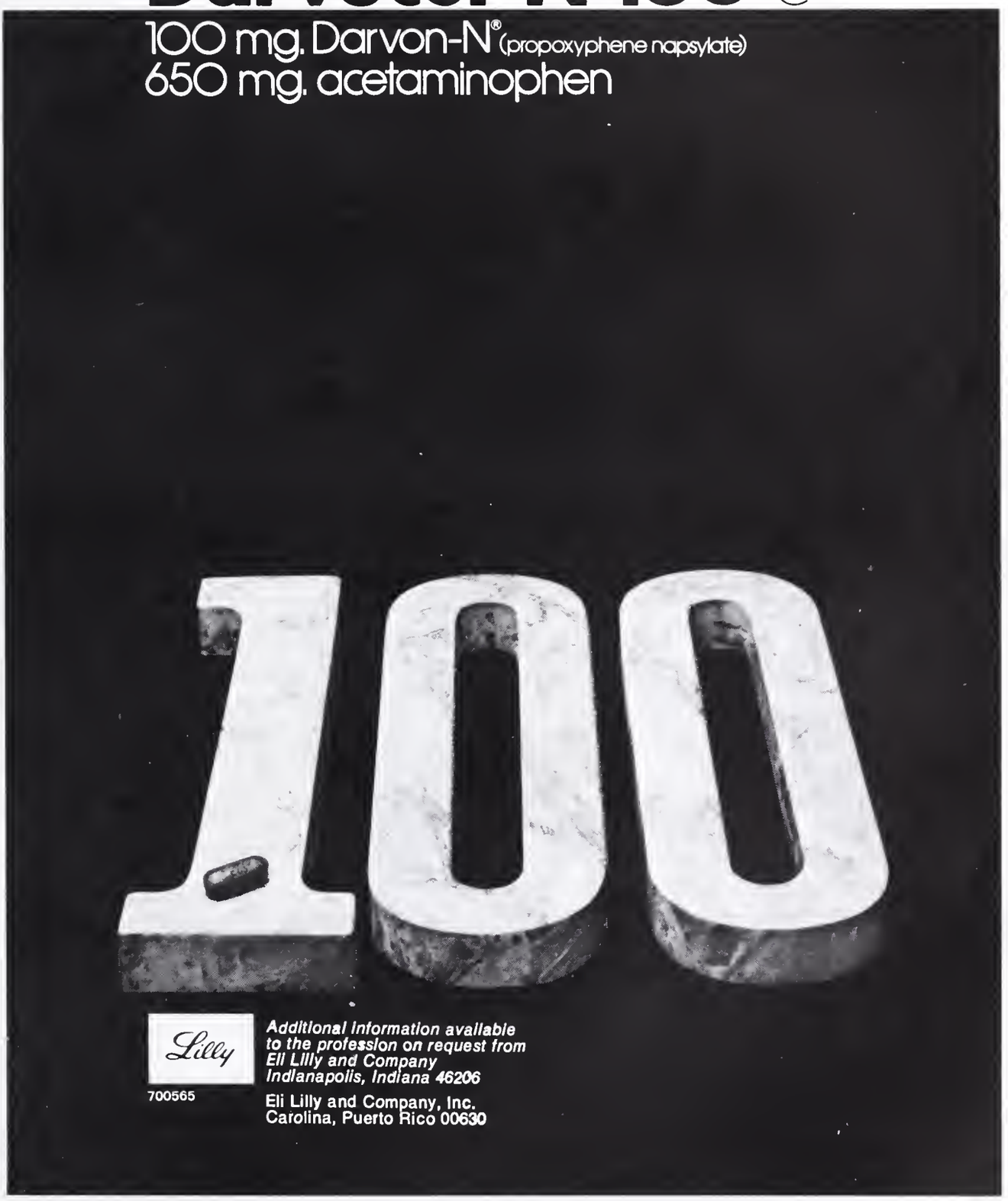
Noon and Night

contains no aspirin

tablets

Darvocet-N® 100 (IV)

100 mg. Darvon-N® (propoxyphene napsylate)
650 mg. acetaminophen

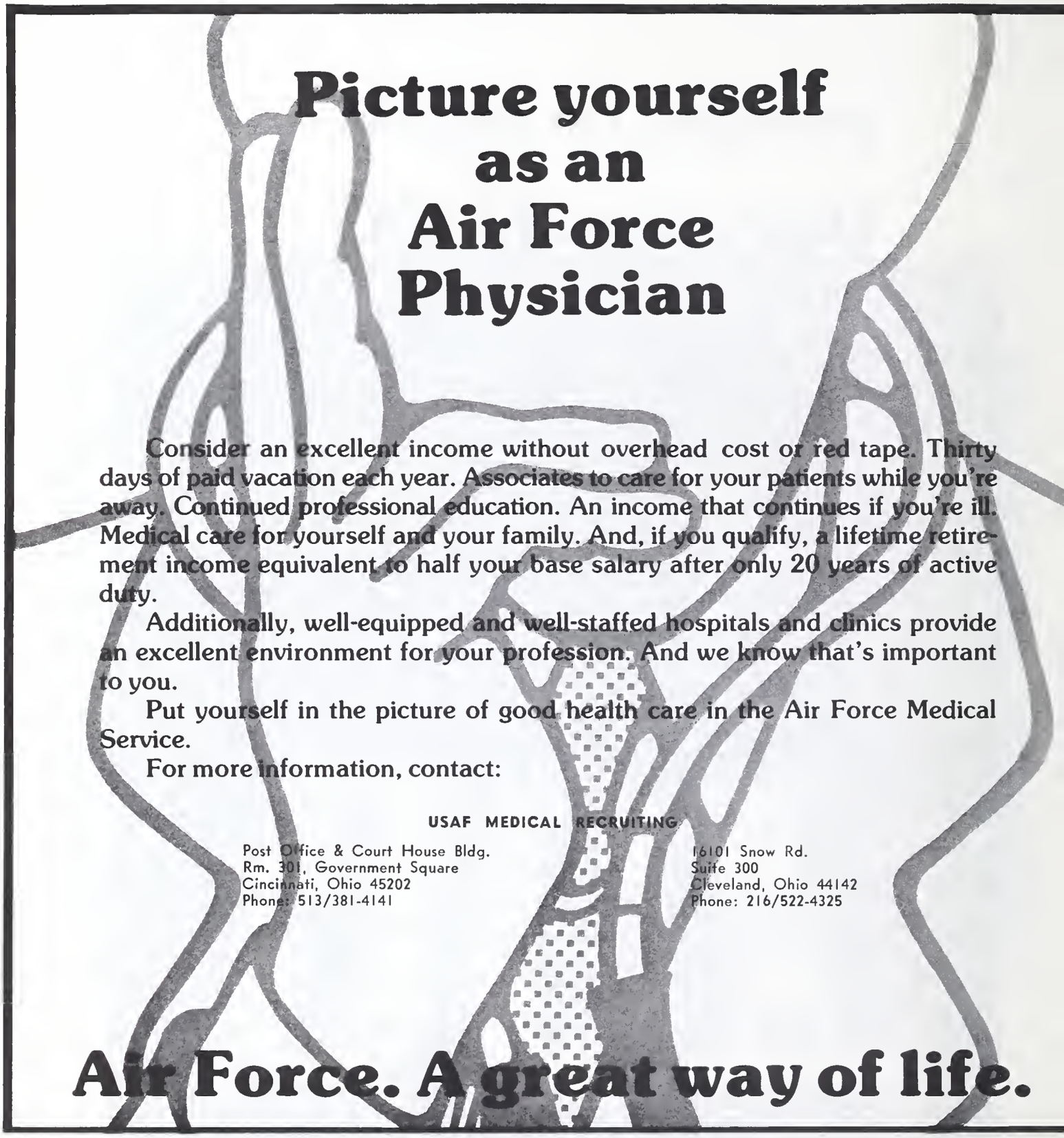


Lilly

Additional information available to the profession on request from Eli Lilly and Company Indianapolis, Indiana 46206

700565

Eli Lilly and Company, Inc.
Carolina, Puerto Rico 00630



Picture yourself as an Air Force Physician

Consider an excellent income without overhead cost or red tape. Thirty days of paid vacation each year. Associates to care for your patients while you're away. Continued professional education. An income that continues if you're ill. Medical care for yourself and your family. And, if you qualify, a lifetime retirement income equivalent to half your base salary after only 20 years of active duty.

Additionally, well-equipped and well-staffed hospitals and clinics provide an excellent environment for your profession. And we know that's important to you.

Put yourself in the picture of good health care in the Air Force Medical Service.

For more information, contact:

USAF MEDICAL RECRUITING

Post Office & Court House Bldg.
Rm. 301, Government Square
Cincinnati, Ohio 45202
Phone: 513/381-4141

16101 Snow Rd.
Suite 300
Cleveland, Ohio 44142
Phone: 216/522-4325

Air Force. A great way of life.

OHIO Medical Association News

Revised Standards for Emergency Care Services Are Published

JCAH has published revised standards for emergency care services that classify hospital emergency departments by four levels of care. Although these standards will not be effective for accreditation purposes until January 1, 1979, they will be used for consultation during on-site surveys conducted in 1978. Level I requires comprehensive 24-hour emergency care service, at least one experienced emergency care physician on duty in the department area, in-house physician coverage for several specific specialty services, and the availability of other specialty service consultation within 30 minutes. Level II requires 24-hour service, at least one experienced emergency care physician on duty, and specialty consultation within 30 minutes. Level III requires 24-hour service and at least one physician available within 30 minutes through a call roster. Level IV requires life-saving first aid and referral to the nearest facility with the appropriate services.

Oregon Blue Shield Gives Grant to Medical School

A health care costs program for medical students at the University of Oregon School of Medicine will be financed by a $100,000 grant from Oregon Physicians Service-Blue Shield. The grant is believed to be the first of its kind. Last year at the AMA's Interim Meeting, the House of Delegates passed a resolution urging medical schools to institute cost-awareness programs. In a related action last spring, the nation's medical school deans "urged the corporate community . . . and the general public to provide the financial support we need to underwrite new teaching methods and curricular experiments."

New Hospital Accreditation Manual Available

All hospital accreditation requirements are contained in the latest edition of *Accreditation Manual for Hospitals*. Published by the Joint Commission on Accreditation of Hospitals, the standards became effective upon publication. Future editions of the *Manual* will be published annually in August, beginning this year, and will contain requirements that become effective the following January. The JCAH has also published a monograph on Medical Staff Bylaws. Both the manual ($20) and the monograph ($6) may be ordered through the Publications Manager, JCAH, 875 N. Michigan Ave., Chicago, Ill. 60611.

Medical Board Activity

The following is a list of activities and actions undertaken from January 1, 1977 to December 31, 1977 by the Ohio State Medical Board.

LICENSURE ACTIVITY

American and Canadian Graduates		
Licensed by Endorsement	M.D.	710
	D.O.	124
Licensed by Examination	M.D.	119
	D.O.	4
Foreign Medical School Graduates		
Licensed by Endorsement		400
Licensed by Examination		117
Sept. 1972 FLEX Board Policy Licenses		29
Endorsements to Other States	M.D.	525
	D.O.	34

ENFORCEMENT ACTIVITY

Formal Citations Issued	14
Board Office Visits with Individuals in Alleged Violation of the Medical Practice Act	60
Voluntary Surrenders of Medical Certificates	7
Arrests for Alleged Illegal Practice of Medicine	10
Formal Hearings on Alleged Violations of the Medical Practice Act	17

(News continued on page 334)

In Columbus
for over 65 years, since 1909,
K. A. Menendian
has been known for
the finest quality and best values in
ORIENTAL RUGS.

We carry a complete selection of rugs from mats to mansion sizes. Over 1500 rugs in stock from Iran, India, China, Pakistan, Turkey, etc.

See over 4,000 samples in our newly remodeled carpet showroom from Karastan and other fine mills.

We specialize in Oriental rug cleaning and repairing.

K.A.Menendian
1090 West Fifth Avenue
294-3345



Heart Association Revises Bacterial Endocarditis Statement

The American Heart Association has revised its statement on Prevention of Bacterial Endocarditis. Approved by the Council on Dental Therapeutics of the American Dental Association, the statement emphasizes the seriousness of the condition and points out the responsibilities of physicians and dentists who care for patients with congenital, rheumatic, and other acquired forms of valvular heart disease. A Bacterial Endocarditis Wallet Card, designed for patients with rheumatic fever or congenital heart disease who need protection from bacterial endocarditis when undergoing medical or dental treatment, also has been issued. Both the Prevention of Bacterial Endocarditis statement and the wallet card are available from American Heart Association offices in Akron, Canton, Cincinnati, Cleveland, Columbus, Dayton, Toledo, and Youngstown.

Update of CPT-4 Published

An update of the fourth edition of *Current Procedural Terminology* (CPT-4) has been published. The 38 revisions include new codes for mastectomy procedures, cryosurgery, and foot surgery, and deletions of outmoded processes. The update is available at no additional cost and can be obtained by using a prepaid mailer in the back of the book. CPT-4 computer tapes have also been revised.

Limited Work Week Asked for Medical Students and House Staff

The American Medical Student Association has passed a resolution stating that medical students and house staff should not be required to work more than 80 hours per week. Approved at the Association's annual meeting March 2-5, 1978, the resolution says that the amount of continuous on-call duty should not exceed 24 hours and should be followed by, or include, a period of rest of not less than six hours.

Medical Malpractice Act of Indiana Ruled Constitutional

According to a recent federal court ruling, Indiana's Medical Malpractice Act is constitutional on all issues, which include a financial liability ceiling and a pretrial review panel. The United States District Court for Northern Indiana upheld the 1975 law's $100,000 limit on the liability of each health care provider for each instance of

TREAT THE SYMPTOMS IN THE GERIATRIC PATIENT

APATHY • IRRITABILITY
FORGETFULNESS • CONFUSION



Cerebro-Nicin® CAPSULES

A GENTLE CEREBRAL STIMULANT & VASODILATOR FOR GERIATRIC PATIENTS

Each CEREBRO-NICIN capsule contains:
Pentylenetetrazole .....100 mg. • Nicotinic Acid ...100 mg.
Ascorbic Acid .....100 mg. • Thiamine HCl .....25 mg.
l-Glutamic Acid .....50 mg. • Niacinamide .....5 mg.
Riboflavin .....2 mg. • Pyridoxine HCl .....3 mg.
AVAILABLE: Bottles 100, 500, 1000
SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and abdominal cramps. The reaction is usually transient.
INDICATIONS: As a cerebral stimulant and vasodilator.
RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.
WARNING: Overdosage may cause muscle tremor and convulsions.
CONTRAINDICATIONS: Epilepsy or low convulsive threshold.
CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

Write for literature and samples . . .
BROWN THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057

medical malpractice and the $500,000 limit on recoverable damages. The balance of judgments awarded in excess of provider liability is paid by the law's patients' compensation fund. The court also upheld the constitutionality of submitting medical malpractice claims to a pretrial review panel consisting of four physicians and a lawyer, whose findings are admissible in court as evidence.

Dayton Hospital Opens Day Surgery Unit

The Children's Medical Center of Dayton has initiated a new Day Surgery Unit. Designed to meet the special needs of children from infancy to 21 years of age, the unit is used by basically healthy children requiring only limited surgery. Patients are admitted to the unit two hours prior to surgery and are released several hours after the operation. This service eliminates the traditional overnight stay for patients and families thereby cutting costs and making the surgery less traumatic.

Hospital Rate Increase Reduction

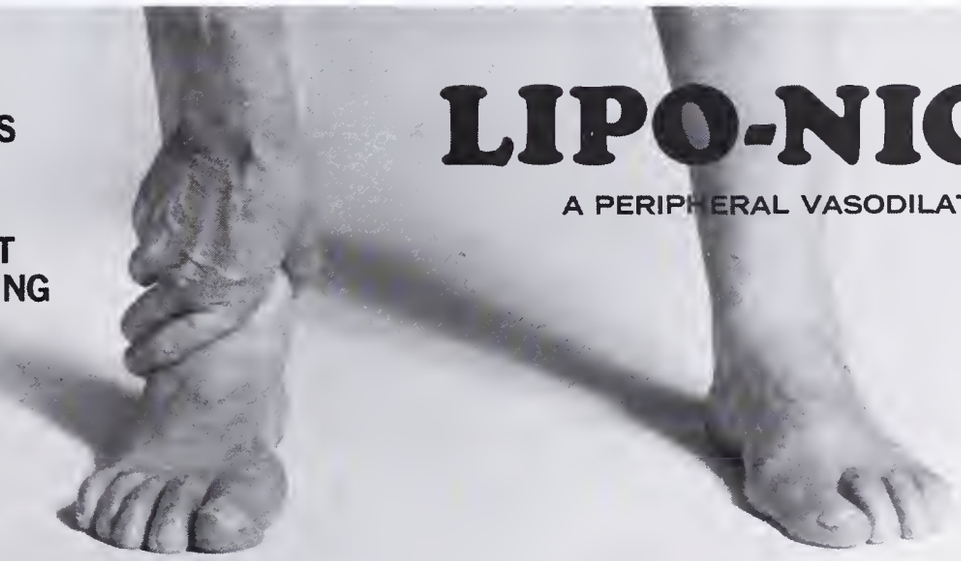
A 15-point plan featuring a goal of a 2% reduction in the rate of increase over each of the next two years in community hospital expenditures has been drafted by the national steering committee that is developing a Voluntary Cost Containment Program. The committee was formed late last year by the AMA, the American Hospital Association, and the Federation of American Hospitals. Describing the project as "a more concerned effort than any undertaken before," an AMA spokesman said a goal of the program will be to expand public awareness of the need for cost constraints and cost awareness on the part of consumers as well as providers.

Ohio Libraries Offer Services to the Handicapped

The State Library of Ohio has published a second edition of *Libraries for People With Handicaps*. For each public library in Ohio, it lists services and materials which can be used by people who cannot go to the library or use ordinary print. It also shows the features of each library building which permit access to people with physical disabilities. Also, there is a summary chart which highlights services, materials, and accessibility of libraries in each county.

Free copies of this directory are available from Services to the Handicapped, The State Library of Ohio, 65 South Front Street, Columbus, Ohio 43215, phone: 614/466-3710.

COLD FEET
LEG CRAMPS
TINNITUS
DISCOMFORT ON STANDING



LIPO-NICIN
A PERIPHERAL VASODILATOR

IMMEDIATE or GRADUAL
nicotinic acid therapy

IMMEDIATE RELEASE

LIPO-NICIN/100 mg.
Each blue tablet contains:
Nicotinic Acid .....100 mg.
Niacinamide ..... 75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .. 25 mg.
Riboflavin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6).. 10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500, 1000.

LIPO-NICIN/250 mg.
Each yellow tablet contains:
Nicotinic Acid .....250 mg.
Niacinamide ..... 75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .. 25 mg.
Riboflavin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6).. 10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500, 1000.

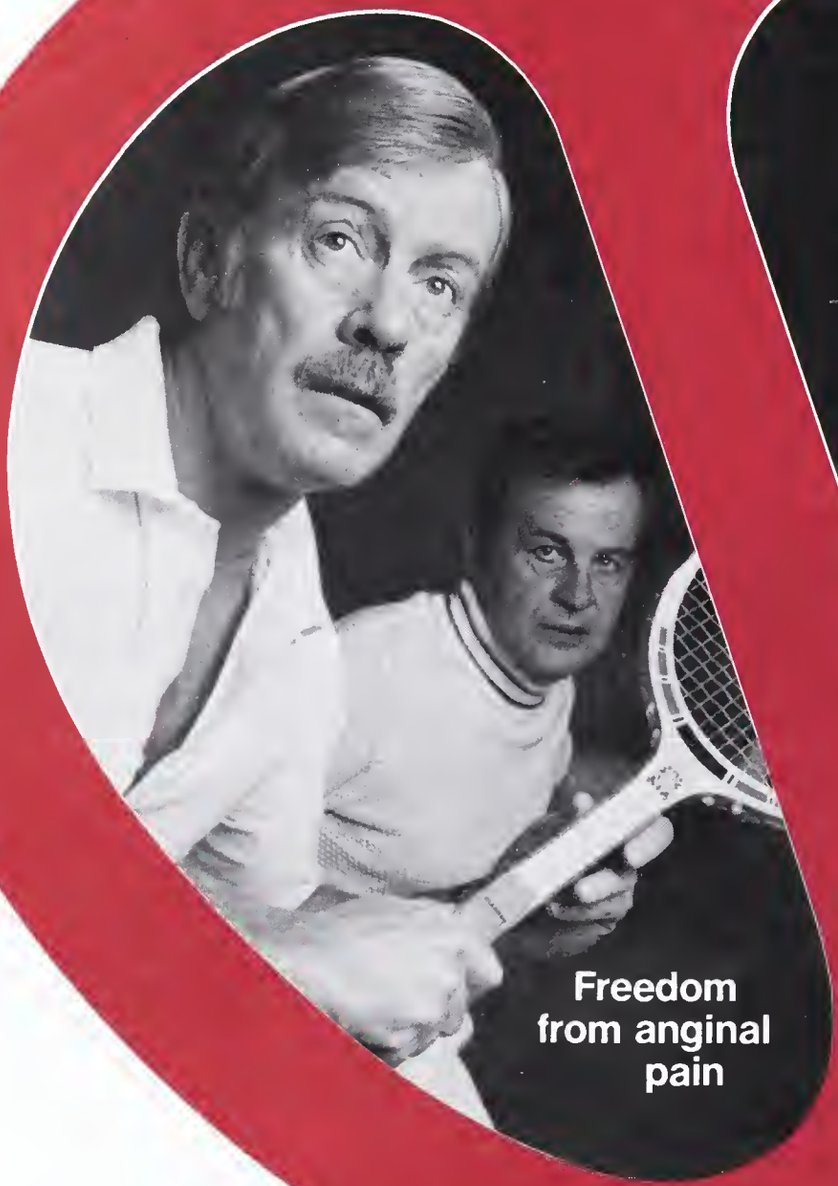
GRADUAL RELEASE

LIPO-NICIN/300 mg.
Each time-release capsule contains:
Nicotinic Acid .....300 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (H-1) .. 25 mg.
Riboflavin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6).. 10 mg.
In a special base of prolonged therapeutic effect.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient. Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur. Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

BROWN THE BROWN PHARMACEUTICAL CO., INC. 2500 West Sixth Street, Los Angeles, California 90057
Write for Literature and Samples
REFER TO PDR

Angina freedom fighter...



Freedom from anginal pain



Freedom from anginal fear

1. Taken sublingually, Cardilate® (erythrityl tetranitrate) begins to work within 5 minutes, eliminating or reducing frequency and severity of anginal pain for up to two hours.
2. Fear of pain, a major deterrent to achieving acceptable (and desirable) levels of activity, including sex, may be allayed with Cardilate. Effective prophylaxis and improved exercise tolerance help toward normalizing the lives of anginal patients.

Cardilate®
(erythrityl tetranitra

Cardilate® (erythrityl tetranitrate)
INDICATIONS: For the prophylaxis and long-term treatment of patients with frequent or recurrent anginal pain and reduced exercise tolerance associated with angina pectoris, rather than for the treatment of the acute attack of angina pectoris, since its onset is somewhat slower than that of nitroglycerin.

PRECAUTIONS: As with other effective nitrites, some fall in blood pressure may occur with large doses.

Caution should be observed in administering the drug to patients with a history of recent cerebral hemorrhage, because of the vasodilation which occurs in the area Although therapy permits more normal activity, the patient should not be allowed to misinterpret freedom from anginal attacks as a signal to drop all restrictions.

SIDE EFFECTS: No serious side effects have been reported. In sublingual therapy, a tingling sensation (like that of nitroglycerin) may sometimes be noted at the point of tablet contact with the mucous membrane. If objectionable, this may be mitigated by placing the tablet in the buccal pouch. As with nitroglycerin or other effective nitrites, temporary vascular headache may occur during the first few days of therapy. This can be controlled by temporary dosage reduction in order to allow adjustments of the cerebral hemodynamics to the initial marked cerebral vasodilation. These headaches usually disappear within one week of continuous therapy but may be minimized by the administration of analgesics.

Mild gastrointestinal disturbances occur occasionally with larger doses and may be controlled by reducing the dose temporarily.

HOW SUPPLIED: 10 mg chewable scored tablets, bottle of 100. Also 5, 10 and 15 mg oral/sublingual scored tablets in bottles of 100. 10 mg oral/sublingual scored tablets also supplied in bottles of 1,000.

Also available: Cardilate®-P brand Erythrityl Tetranitrate with Phenobarbital* Tablets (Scored).

(*Warning—may be habit-forming.)



Wellcome **Burroughs Wellcome Co.**
Research Triangle Park
North Carolina 27709

OHIO STATE MEDICAL ASSOCIATION

Medical School Highlights

Library Needs Journals and Texts

The Basic Medical Sciences Library of the Northeastern Ohio Universities College of Medicine is seeking both texts and back volumes of various journals to fill out its collection. The library needs basic sciences materials as well as clinical titles. Materials dated from 1950 to 1975 are most sought after, but the library might take older materials if they are part of a complete set from volume one. Texts should have been printed either before 1870 or after 1970.

The NEOUCOM library will pay postage or shipping charges and will acknowledge by letter receipt of all items. Inquiries should be directed to Mrs. Jan O'Halloran, Serials Assistant, Basic Medical Sciences Library, Northeastern Ohio Universities, College of Medicine, Rootstown, Ohio 44272.

Case Awarded Pharmacology Grant

The Pharmacology Department of the Case Western Reserve University School of Medicine has been awarded a one-year grant of $150,000 by the Rockefeller Foundation, New York City. This grant is to be used to study drug forms used in the treatment of parasitic diseases found in tropical and subtropical countries. Department Chairman Leslie T. Webster, M.D., said that this grant links Case Western Reserve University's pharmacoparasitology research unit to other research units throughout the world funded by the Rockefeller Foundation. This eight-group network is dedicated to investigating the "great neglected diseases" which afflict millions annually. Among the diseases Dr. Webster expects to investigate is schistosomiasis, which affects more than 150 million persons each year.

Medical School Plans Expansion

Northeastern Ohio Universities College of Medicine is planning expansion of student class sizes. Stanley W. Olson, M.D., Provost of the College, told board members at a January 1978 meeting: "We shall request in March 1978 that the Phase II entering class for September 1979 be increased to 60 students from the 48 presently enrolled. The LCME (Liaison Committee on Medical Education) may permit us to accept the additional 12 students tentatively, subject to a decision to be made after the April 1979 visit. According to Dr. Olson, the proposed schedule for increasing the class size is as follows: September 1979 — 60 students; September 1981— 76 students; September 1983— 92 students; and September 1985— 100 students.



If Our Area Manager Isn't In Maybe Our Secretary Can Help

Our Blue Shield professional relations managers are busy people, constantly out calling on doctors and their office staffs. Which means that if you phone, the area manager may not be in at that moment.

However, expert help may still be available. The area office secretaries are trained and capable in providing assistance with the more common and frequent kinds of matters.

They can check on the status or disposition of claims, answer questions about whether a certain service is payable under a specific contract or find out if the patient is a currently enrolled Blue Shield subscriber.

We take our service seriously...all of us.

Blue Shield

Ohio Medical Indemnity, Inc.

6740 North High Street, Worthington, Ohio 43085

THE OHIO STATE Medical Association New Members

ASHLAND (Loudonville)
Daniel R. Daugherty
John P. Jentes

ASHTABULA
Cheng-Nan Huang, Geneva
Syed A. Hussaini, Geneva
Seung C. Karl, Conneaut
Soon Ha Park, Conneaut

BROWN
Adolph A. Gruber, Bethel
Dhanemkula Mohangandhi, Ripley

BUTLER (Oxford)
Elzworth C. Wiesenmayer

CUYAHOGA (Cleveland)
Azzam Ahmed
Gloria V. Apolonio
Anthony C. Breuer
Hyun Ja Chung
Shahpour Esfandiari
Albert Gulledge
Neal E. Krupp
Armando Lenis
Rosalinda D. Seballos
Hernando Zegarra

FRANKLIN (Columbus)
Maheswora N. Baidya
Mike Bauerschmidt
Arthur Z. Filiatraut
Otilia A. T. Marina
Philip A. Rogers
Edwin H. Season, III
Bruce Spring

GREENE (Xenia)
Ronald Taylor

HAMILTON (Cincinnati unless noted)
Bennett A. Anyaegbu
Antonio L. Escamilla, Erlanger, Ky.
David M. Kesterson
Michael A. Newton
David J. Quenelle
Jeffrey Wm. Willbrand

HOCKING (Logan)
Roy R. Bontrager
Donald B. Twiggs

LICKING
Bruce Dawson, Granville
David T. Harper, Newark

LUCAS (Toledo unless noted)
Joseph J. Baum
Eva Bernblum, Maumee
Gerald Cichocki
Gary Crawford
Teresita T. Domini
Segunda S. Eudela, Sylvania
Luis R. Gerstenmaier
Timothy B. Hacker
Howard A. Joos
Michael S. Mack
Mohammad Mahboob
Richard H. Mauk
Legaspi M. Punsalan
Champa K. Ratra, Oregon
Paul L. Schaefer
Stephen A. Skiver, Maumee
Charles R. Snyder

MEDINA (Lodi)
Jorge E. Motta

MONTGOMERY (Dayton)
Allen K. Callender
Mehdi Ghaheri
Shaikh B. Islam
James M. Linta

SENECA
William A. Cook, Tiffin
Pramuan Thirasilpa, Fostoria

SUMMIT (Akron unless noted)
V. Balasubramanian, Twinsburg
Quirino Dubria
William Gardner
Thomas L. Haynes, Barberton
Jeffrey W. Yatsu

TRUMBULL (Warren)
Leovigildo E. Barboza

TUSCARAWAS (New Philadelphia)
Kanubhai Patel

WILLIAMS (Bryan)
David M. Roebuck
Robert Sharrock



WINDSOR HOSPITAL
A NONPROFIT CORPORATION
— ESTABLISHED 1898 —
Chagrin Falls, Ohio
247 - 5300

A hospital for the treatment of Psychiatric Disorders

High on a Hill-Top, Overlooking Beautiful Chagrin River Valley.

Accredited by Joint Commission on Accreditation of Hospitals.
Booklet available on request.

FRIEDRICH A. LINGL, M.D. Medical Director
GUY H. WILLIAMS, JR., M.D. Medical Director Emeritus
HERBERT A. SIHLER Jr. President

MEMBER: American Hospital Association—National Association of Private Psychiatric Hospitals

Colleagues in the News

I. LEONARD BERNSTEIN, M.D., Cincinnati, is a member of the 1978 Executive Committee of the American Academy of Allergy. The Academy has a membership of nearly 3,000 physicians and research scientists specializing in diagnosis, care, and study of allergic diseases.

NORMAN H. BLASS, M.D., has been appointed Associate Professor, Department of Anesthesiology and Department of Obstetrics and Gynecology, Wright State University School of Medicine. A Diplomate of the American Board of Obstetrics and Gynecology and a Fellow of the American College of Anesthesiologists, Dr. Blass previously served as Assistant Professor of Anesthesiology, University of California School of Medicine, Davis.

THOMAS B. BRALLIAR, M.D., University Heights, is the newly elected president of the Cleveland Society of Anesthesiologists. Other officers are **THOMAS J. LAVIN, M.D.,** Cleveland Heights, vice-president; **BETTY L. GRUNDY, M.D.,** Shaker Heights, secretary; and **MICHELLE FUMIERE, M.D.,** Rocky River, treasurer.

DENNIS BROOKS, M.D., Cleveland, has been promoted to Assistant Clinical Professor of Orthopedic Surgery at Case Western Reserve University School of Medicine. Dr. Brooks also is a member of the medical staff of Huron Road Hospital.

JAMES CERILLI, M.D., Columbus, has been elected Secretary of the American Society of Transplant Surgeons. Dr. Cerilli is Professor of Surgery at The Ohio State University College of Medicine.

A. ROBERT DAVIES, M.D., Troy, has been named Chairman of the Department of Medicine, Wright State University School of Medicine. Dr. Davies served in this capacity on an acting basis since March 1977. Prior to joining the School of Medicine in 1976 as Associate Professor of Medicine and Director of the Group in Internal Medicine, he served as chief of staff at both Stouder Memorial and Dettmer Hospitals, Troy.

THOMAS L. GAVAN, M.D., Bay Village, is the recipient of the 1977 "Outstanding Contribution to Microbiology" award presented by the South Central Association of Clinical Microbiology. A member of the staff of the Cleveland Clinic since 1966, Dr. Gavan heads the Department of Microbiology.

RAY W. GIFFORD, M.D., Cleveland Heights, received two honors recently. Head of the Cleveland Clinic's Department of Hypertension and Nephrology, he was named to the board of directors of "Dialogues in Hypertension," a continuing education program for physicians in the field of hypertension. In addition, Dr. Gifford will represent the AMA on the National High Blood Pressure Coordinating Committee. This is an advisory group to the National High Blood Pressure Education Program of the Department of Health, Education, and Welfare.

ROBERT GILLETTE, M.D., Toledo, has been elected to the Board of Directors of the Family Practitioners of Toledo and Lucas County. Dr. Gillette is a member of the Medical Staff of Riverside Hospital.

CLAUDE S. HAMBRICK, M.D., Dayton, has been certified by the American Board of Family Practice. Dr. Hambrick is Assistant Professor, Department of Family Practice, Wright State University School of Medicine.

SCOTT R. INKLEY, M.D., Cleveland, has been appointed Chief of Staff of University Hospitals of Cleveland effective September 1, 1978. Currently Director of the Adult Respiratory Therapy Department at the hospital and Professor of Medicine at Case Western Reserve University School of Medicine, he will succeed Walter H. Pritchard, M.D., who has served as chief of staff since 1971. Dr. Inkley is a leader in the research and treatment of lung diseases, a member of the board of directors of the Cleveland Academy of Medicine, and directs the School of Medicine's first major effort in continuing education for physicians.

F. LAMONT JENNINGS, M.D., has been appointed Professor and Chairman of the Department of Pathology, Wright State University School of Medicine. Board-certified in pathologic anatomy, Dr. Jennings comes from the University of Texas Medical Branch, Galveston, where he was Professor of Biology.

Also joining the Department of Pathology is **AL BATATA, M.D.,** appointed Associate Professor. Dr. Batata is a former assistant professor of pathology at the Medical College of Wisconsin, Milwaukee.

C. DAVID JOFFE, M.D., Dayton, is the author of a newly released book entitled *Practical Echocardiography: A Basic Manual.* The book was written for physicians, technicians, nurses, and medical students without previous training in echocardiography and without previous knowledge of the physics of ultrasound. Dr. Joffe is Director of Cardiography at Good Samaritan Hospital and Health Center, Dayton, and Assistant Clinical Professor of Cardiology, Wright State University School of Medicine. His book has been published by the Charles Press Publishers, Bowie, Maryland.

SOLOMON LEVIN, M.D., Akron, has been appointed Chairman of the Council of Psychiatry for Northeastern Ohio Universities College of Medicine. Dr. Levin comes to Ohio from the positions of Professor and Director of Postgraduate Education, McMaster University School of Medicine, Hamilton, Ontario. He also will serve as Chairman of the Department of Psychiatry, Akron General Medical Center.

TEARLE L. MEYER, M.D., Columbus, has been elected President of the Grant Hospital Medical Staff. A member of the Grant staff since 1966, Dr. Meyer is a Fellow of the American College of Radiology and a clinical instructor at The Ohio State University College of Medicine. Other officers are **WARREN H. LEIMBACH, M.D.,** president-elect; and **JACK MARKS, M.D.,** secretary-treasurer. Dr. Leimbach is a Fellow of the American College of Surgeons and a clinical assistant professor at OSU. Certified by the American Board of Internal Medicine, Dr. Marks is a Fellow of the American College of Physicians and a clinical assistant professor at OSU.

In addition to these positions, three new department chairmen have been elected at Grant Hospital: Dr. Leimbach, Chairman of the Department of Surgery; **JAMES A. HARDIE, M.D.,** Chairman of the Department of Family Practice; and **DAVID A. UCKER, M.D.,** Chairman of the Department of Obstetrics and Gynecology.

CALVIN R. PETERS, M.D., Cleveland, has been appointed to the staff of the Department of Plastic Surgery at the Cleveland Clinic. Dr. Peters comes to this position from Duke University Medical Center, Durham, North Carolina, where he was Assistant Professor of Plastic and Maxillofacial Surgery.

RONALD F. SWANGER, M.D., Cleveland, has been named a vice-president of the Metropolitan Health Planning Corporation. Prior to this appointment, he served as Director of the City of Cleveland Department of Public Health and Welfare. Dr. Swanger is a diplomate of the American Board of Pediatrics and is Assistant Clinical Professor of Pediatrics at Case Western Reserve University School of Medicine.

THOMAS G. THORNTON, M.D., Dayton, has been appointed Diplomate for the Subspecialty of Cardiovascular Disease by the American Board of Internal Medicine. Dr. Thornton is Assistant Clinical Professor of Medicine, Wright State University School of Medicine.

HERMAN A. TOLBERT, M.D., Columbus, has been appointed Director of the Child Psychiatry Outpatient Clinic at The Ohio State University Hospitals and Assistant Professor of Psychiatry at the College of Medicine. Dr. Tolbert is a member of the Neuropsychiatric Society of Central Ohio and the American Academy of Child Psychiatrists.

This year . . . the chances of your being seriously disabled are far greater than death.

THIS CHART SHOWS JUST HOW MUCH GREATER.

CHANCES OF DISABILITY VS. DEATH	
If you are age	A disability of 90 days or longer is this much more likely to occur than death this year
22	7½ TIMES GREATER
32	6½ TIMES GREATER
37	5½ TIMES GREATER
42	4 TIMES GREATER
47	3½ TIMES GREATER
52	2½ TIMES GREATER
62	2 TIMES GREATER

Source: The National Underwriter Company 420 E. 4th St. Cincinnati, Ohio 45202

When disability occurs, will your protection be adequate?

To be sure you have an income when you're disabled, enroll in . . .
THE DISABILITY INCOME PROTECTION PLAN which your Ohio State Medical Association co-sponsors with many local medical societies. You may apply for benefits up to $500 weekly.

CONTACT:

TURNER AND SHEPARD INC.

Columbus, Ohio 43215	17 South High Street	Phone (614) 228-6115
Akron, Ohio 44313	3090 West Market Street	Phone (216) 434-5000
Cincinnati, Ohio 45241	4015 Executive Park Drive	Phone (513) 563-4220
Cleveland, Ohio 44134	1440 Snow Road	Phone (216) 741-4466
Toledo, Ohio 43606	3450 West Central Avenue	Phone (419) 535-0616

OSMA Placement Service Ads

In order to promote retention in Ohio of physicians who trained in the State, ***The Journal***, in cooperation with the OSMA Department of Field Service, offers classified advertising listings at no charge to physicians-in-training desiring to practice in Ohio. Persons eligible for this service must be graduates of Ohio medical schools and/or persons who are completing an internship or residency program at an Ohio institution. They must also be currently in a medical training program or in the United States Armed Forces (or some other U.S. government service).

All classified ads will be printed anonymously by use of box numbers in a special classified ad section of ***The Journal***. Replies to the ads will be channeled through the Department of Field Service, which will assist in the location process. (Replies are otherwise confidential.) Ads will be printed as frequently as space permits. (See previous issues of ***The Journal*** for additional listings.)



PSYCHIATRIST: Also general medicine. Available July 1978. Desires location in suburban metropolitan, metropolitan, or inner city community in areas 1, 4, or 5. Population 15,000-1-million. Very flexible as to type of practice. Eligible for specialty board examination July 1978. Contact Box P-6 c/o Ohio State Medical Journal.

SURGEON: General. Available July 1978. Desires location in area 3 in community that is rural with metropolitan ties, suburban metropolitan, or metropolitan. Population 50,000-100,000. Prefers group practice. Eligible for specialty board July 1978. Contact Box P-5 c/o Ohio State Medical Journal.

INTERNIST: With cardiology subspecialty including invasive cardiology. Currently available. Desires location in areas 1, 2, 3 or 5 in suburban metropolitan or metropolitan community with population of 50,000 to 500,000. Prefers group practice. Contact Box P-18 c/o Ohio State Medical Journal.

ANESTHESIOLOGIST: Currently available. Desires small group practice in metropolitan area with population 50,000-500,000. No preference as to area of state. Contact Box P-10 c/o Ohio State Medical Journal.

GENERAL PRACTITIONER: Available July 1978. Prefers location in area 3 in community that is suburban metropolitan or metropolitan with population of 50,000-500,000 but will consider others. Desires solo or group practice; willing to take over a practice. Contact Box P-27 c/o Ohio State Medical Journal.

EMERGENCY PHYSICIAN: Available July 1979. Desires group practice in community that is rural with metropolitan ties with population of 15,000-50,000. Eligible for specialty board examination July 1979. Contact Box P-22 c/o Ohio State Medical Journal.

OBSTETRICIAN / GYNECOLOGIST: Available July 1978. Desires community that is rural with metropolitan ties or suburban metropolitan with population 50,000 to 100,000. Prefers solo or small group practice. Eligible for specialty board examination July 1978. Contact Box P-12 c/o Ohio State Medical Journal.

PEDIATRICIAN: Available July 1978. Desires location in area 2 in community that is rural with metropolitan ties or suburban metropolitan with population of 15,000-100,000. Interested in solo, group, governmental or institutional practice. Contact Box P-28 c/o Ohio State Medical Journal.

INTERNIST: With pulmonary medicine sub-specialty. Available July 1978. Diplomate of Board of Internal Medicine. Eligible for specialty board examination in pulmonary medicine in 1978. Desires community that is suburban metropolitan or metropolitan with population of 15,000-1 million. Interested in group or industrial practice with part-time academic appointment. Contact Box P-26 c/o Ohio State Medical Journal.

INTERNIST: With cardiology subspecialty available July 1978. Diplomate of the Board of Internal Medicine. Eligible for the specialty board examination in cardiology in 1978. Desires community that is rural with metropolitan ties or suburban metropolitan with population of 15,000-100,000. Prefers solo or small group practice. Contact Box P-25 c/o Ohio State Medical Journal.

INTERNIST: With gastroenterology subspecialty available July 1978. Passed specialty board examination June 1977. Desires location in areas 2, 3, 4 or 5 in suburban metropolitan or metropolitan community with population of 15,000 to 100,000. Interested in small group practice with part-time academic appointment, full-time academic appointment or governmental position. Contact Box P-21 c/o Ohio State Medical Journal.



THE WENDT-BRISTOL COMPANY
1159 DUBLIN ROAD
COLUMBUS, OHIO 43215
614/486-9411

MEDICAL/SURGICAL PRODUCTS
LABORATORY PRODUCTS
SPECIALTY PRODUCTS
PHARMACEUTICALS
PATIENT AIDS
INSTRUMENTS
FURNITURE

A Medical Breakthrough!

The Paperwork Transplant

Paperwork. It's become one of the most time consuming and costly jobs in medicine. But the computer terminal you see here is starting to change all that. With it in your office, one of your staff can "transplant" your paperwork for processing through the Nationwide Professional Services central computer facility.



A successful operation is the result of finely honed surgical instruments in the hands of a skilled surgeon, supported by an experienced team.

Now, Nationwide Professional Services Corporation has applied this proven formula to the task of removing the burden of paperwork from your office.

Through this terminal comes a finely honed accounts receivable program. Placed in the hands of your staff and supported by the service and experience of the Nationwide organization, the paperwork transplant is easily performed each day simply by "typing" in normal patient information, services provided and applicable charges.

Call 614/227-6995 or return this coupon for the full story on how your cash flow can improve.

NPS

NATIONWIDE PROFESSIONAL SERVICES CORPORATION

To: Nationwide Professional Services Corporation
One Nationwide Plaza
Columbus, OH 43216

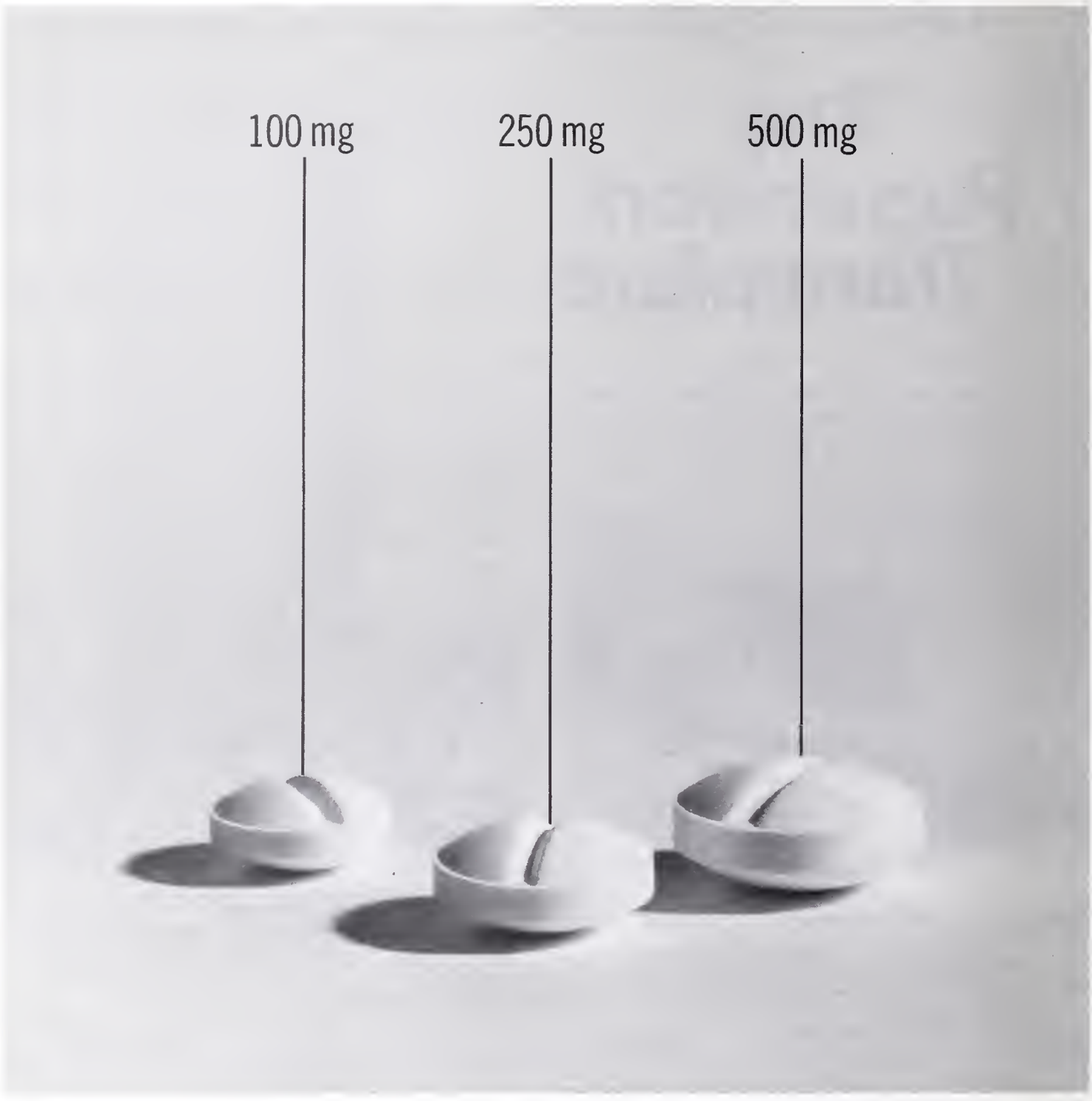
Please call me for an appointment at my convenience.

DOCTOR_____

ADDRESS_____

CITY_____ STATE_____

ZIP_____ TELEPHONE_____



Tolinase®
tolazamide, Upjohn

Please contact your Upjohn representative for additional product information.

Upjohn

J-5695-6

©1977 THE UPJOHN COMPANY

Classified Ads

Rates: $3 per line. Display classified: $5 per line. Minimum 3 lines per insertion. Ads measure 8 lines to the inch. Box number reply: Flat $5 charge in addition to line cost for up to and including three insertions. (Covers cost of mailing replies which are kept confidential.) Forms close the 10th day of the month preceding month of publication. Address all ads Attention: Classified Ad Department, ***The Journal.***

To assure prompt delivery, when replying to an advertisement over a ***Journal*** box number, address letters as follows: Box (insert number), c/o ***The Ohio State Medical Journal***, 600 South High Street, Columbus, Ohio 43215.

PHYSICIAN: With empathy toward college-age population to practice general medicine in 38-bed accredited hospital with large outpatient clinic. Salary negotiable, excellent fringe benefits. Contact I. W. Combs, M.D., Director, Purdue University Student Hospital, West Lafayette, Indiana 47907, phone: 317/749-2441.

Equal Access/Equal Opportunity Employer

MARION, OHIO: Excellent opportunities in Central Ohio. Existing and new, solo, partnerships, or association practices available and seeking physician support. Top compensation— reliable cross coverage. Exceptionally attractive, 250-bed, well-equipped regional medical center hospital within walking distance from offices. Industry and agriculture support city/45,000; county/65,000; and total trade area/250,000. Excellent schools and residential areas. Fifty-minute, easy drive to Columbus. Active need for—

FAMILY PRACTICE
INTERNAL MEDICINE
OTOLARYNGOLOGY
PEDIATRICS
ORTHOPEDIC SURGERY
EMERGENCY MEDICINE
GENERAL SURGERY

We are seeking either rural or city-oriented physicians. Send C.V. or contact— ROBERT FLINT, Marion General Hospital, MARION, OHIO 43302 — or call 614/382-8211 or 382-3442 any time.

PULMONARY PHYSICIAN: An established three-man practice in pulmonary medicine seeks a fourth associate with interests in respiratory therapy, pulmonary function, fiberoptic bronchoscopy, pulmonary rehabilitation, intensive care, and medical school teaching. Excellent opportunity, superb salary, youthful group in western suburbs of Cleveland. Excellent family environment. Call collect 216/226-6666 or reply with CV to Pulmonary Medicine Associates, Inc., 14601 Detroit Avenue, Lakewood, Ohio 44107.

DEPUTY MEDICAL DIRECTOR

Fortune 100 company located in major midwestern metropolitan area has an immediate opening for the deputy medical director. Qualified candidates will possess a minimum of 5 years professional experience as a medical director, with preferred experience in industrial or process manufacturing companies. Emphasis should include epidemiology and/or toxicology. Prefer Board Certification in preventive medicine. Responsibilities include development of administrative practices in industrial hygiene, epidemiology and toxicology, development of centralized medical records system, field direction of industrial positions, interface with various state and federal regulatory authorities and day-to-day involvement with operating departments of the company. Attractive compensation package commensurate with skills and experience relating to the position. Please reply to Box 830 c/o Ohio State Medical Journal.

An Equal Opportunity Employer, M/F/H.

OB/GYN: Needed for multi-specialty group of 16 physicians in expanding facility adjacent to new hospital. Salary and corporate benefits leading to membership after first year. Above-average community for family. Reply Box 828 c/o Ohio State Medical Journal.

CHIEF PATHOLOGIST: Wanted for 200-bed hospital in mid-Michigan. Salary is negotiable. If interested please send notice to Mr. Hugh D. Witham, Administrator, The Memorial Hospital, 826 W. King St., Owosso, Michigan 48867, or call (517) 723-5211-Ext. 811.

HOUSE PHYSICIANS WANTED: For a community hospital located in northeast Ohio. Housing and uniform allowances provided. Attractive fringe benefits, including insurance. Salary negotiable. Must have current Ohio licensure. Reply Box 813 c/o Ohio State Medical Journal.

(Classified Ads continued on page 346)

GENERAL MEDICAL OFFICES AVAILABLE FOR RENT: In Hartville, reportedly the fastest growing township in Ohio. New construction permitting individual furnishing. Physically attached to Cancer Center with diagnostic x-ray, laboratory, and pharmacy facilities. Contact George N. Swallon Agency, Canton, Ohio, 216/456-3495, or inquire of R. K. Loeffler, M.D., 650 South Prospect, Hartville, Ohio 44632.

PHYSICIAN'S ASSISTANT: Certified 1976, seeking employment Reply: 216/351-6511.
(EDITOR'S NOTE: The Journal presents the above classified advertisement to its readers as an announcement of the physician's assistant and assumes no responsibility for the statements made.)

STUDENT HEALTH SERVICE PHYSICIAN: For the University of Cincinnati. Must be able to work well with college-age students. Prefer a physician with clinical experience in any of the listed fields: Internal Medicine, Surgery, Pediatrics, Orthopedics, or Family Practice. Forty-hour week with liberal vacation and excellent fringe benefits, including malpractice insurance. Salary depending on individual. Contact D. I. Charles, M.D. Phone: 513/475-2568.

An Equal Opportunity Employer

OB/GYN: Incorporated obstetrics/gynecology group seeking an additional member. Suburb of medium-size city, midwestern Ohio. Please send curriculum vitae and request for additional information to Box 825 c/o Ohio State Medical Journal.

MEDICAL DIRECTOR: 515-bed rehabilitation hospital seeks a Director qualified by clinical and administrative excellence. The successful candidate will be preferably an internist or physiatrist; board certified; licensed to practice in Ohio; with at least 5 years of clinical practice beyond residency; plus leadership experience, such as an Associate Director or Department Head; and capable in promoting public relations. Responsibility with commensurate authority includes direction of all medical programs, supervision of staff physicians and consultants, and all other facets related to medical directorship. Please send curriculum vitae in confidence to:

C. B. Mueller and R. L. Braddom, M.D.
The Daniel Drake Memorial Hospital
Galbraith Road at Vine Street
Cincinnati, Ohio 45216

An Equal Opportunity Employer M/F

JULY STAFF EMERGENCY DEPARTMENT OPENING: Zanesville, Ohio. A 500-bed modern hospital with excellent backup. Flexible scheduling. Minimum guarantee/fee-for-service income $50,000-$70,000. Only 50 miles from Ohio State University, great recreational area. Send curriculum vitae to Howard Marsh, M.D., Director of Emergency Services, Good Samaritan Medical Center, 800 Forest Avenue, Zanesville, Ohio 43701, or call Toll Free 800/325-3982, Ext. 220.

FOR SALE OR LEASE: Large doctor's office, 5,000 sq. ft. X-ray equipment. 328 E. State Street, Columbus, Ohio, near Grant Hospital. Phone: 614/258-5644.

OPHTHALMOLOGIST: Full-time position with multi-specialty group practice in southwestern Ohio very close to large metropolitan areas but with the advantages of family life in small city. First-year guarantee and excellent fringe benefit package with this incorporated professional group oriented to primary care. Conveniently accessible to continuing educational opportunities and university affiliation. Please reply to Box 829, c/o Ohio State Medical Journal.

EXCELLENT FEE-FOR-SERVICE INCOME: Athens, Ohio. Salary $50,000-$70,000 per year plus. Rapidly expanding emergency department with growth potential. Flexible scheduling. Outstanding university town, home of Ohio University, located in the rolling foothills of southern Ohio. Send curriculum vitae to Eric Jenison, M.D., Director of Emergency Services, O'Bleness Memorial Hospital, Athens, Ohio 45701, or call Toll Free 800/325-3982, Ext. 220.

FAMILY PRACTICE — RURAL PRACTICE: Northwest/central rural/agrarian community of 1200/1500 needs family practice physician. Practice could expand to cover 3000/3500 population area. No physician now practicing. Community will support. Major regional hospital within driving distance. Contact ROBERT FLINT, MARION GENERAL HOSPITAL. MARION, OHIO 43302, phone 614/382-8211 or 382-3442.

MEDICAL DIRECTOR: For new VA Outpatient Clinic opening in Toledo, Ohio, September 1978. Desire ABIM and demonstrated administrative ability. Salary to $50,000, depending on qualifications, with Federal Civil Service benefits. An equal employment opportunity employer. Please send C.V. to Associate Chief of Staff for Ambulatory Care, VA Hospital, 2215 Fuller Road, Ann Arbor, Michigan 48105.

FAMILY PHYSICIAN NEEDED: For Community Health Center. Full-time position for family practice or internal medicine specialty. Good salary and benefits including malpractice insurance. Contact R. M. Borders, Exec. Director, Cordelia Martin Health Center, 1636 W. Bancroft St., Toledo, Ohio 43606. Telephone: 419/473-1438.
Equal Employment Opportunity Employer

PSYCHIATRY RESIDENT

Position available to work as a full-time, first-year resident physician. Duties are to record medical histories, perform physician examinations and follow patients throughout their hospitalizations and as long as necessary for follow-up care. This follow-up care will include ordering laboratory and x-ray exams, conferring and consulting with other health care workers, prescribing medications, and counseling patients, as well as maintaining all written records of these functions. This position will receive direct, close supervision by senior staff members. This is a 48-hour per week position, 8 AM-6 PM, Monday through Friday and 8:30 AM-11:30 AM on Saturday with a salary of $13,800 per year. This position also requires on-call status as needed within the department. Qualified candidates will be graduates of US medical schools and have an ECFMG and VQE Certificate. Must be completely familiar with and able to use EKG monitor and monitor strips and ECT machine. Forward credentials with references to:

Dr. J. P. Duffy, M.D.
Dept. of Psychiatry
Hanna Pavilion
University Hospitals of Cleveland
2040 Abbington
Cleveland, Ohio 44106

INTERNISTS FOR PRIMARY CARE UNIT: Hospital-based practice in Ann Arbor, Michigan available July 1, 1978. Faculty appointment with house staff teaching through affiliation with the University of Michigan. Salary to $40,000 plus, depending on qualifications, with Federal Civil Service benefits. An equal employment opportunity employer. Please send C.V. to Associate Chief of Staff for Ambulatory Care, VA Hospital, 2215 Fuller Road, Ann Arbor, Michigan 48105.

ANESTHESIOLOGY RESIDENT TRAINING PROGRAM: Seeks qualified Ohio applicants. Experience in general practice or primary care preferred. Enquire: Lucien E. Morris, M.D., Department of Anesthesia, Medical College of Ohio, Caller Service #10008, Toledo, Ohio 43699.

RADIOLOGIST

Seventy-bed, not-for-profit community hospital in North Central Ohio is currently seeking a Staff Radiologist, effective immediately. Excellent growth potential in a department now at 15,-500 procedures annually and with new Nuclear Medicine equipment. Superior position for associate or junior member of an existing corporation to have your own radiology department. Must be board certified or eligible in general Radiology and Nuclear Medicine. Send current, detailed curriculum vitate to Box 824, c/o Ohio State Medical Journal.

AMBULATORY CARE CENTER — EMERGENCY DEPARTMENT STAFF PHYSICIAN, ATHENS, OHIO: 20,000 annual patient visits. Flexible scheduling, minimum guarantee/monthly bonus, excellent fringes. Contact Eric Jenison, M.D., O'Bleness Memorial Hospital, Athens, Ohio 45701, or call toll-free 800/325-3982 for details.

PSYCHIATRY STAFF OPENING: Board-eligible or board-certified Psychiatrist in a reorganized service of outpatient-inpatient programs with 479 operating psychiatric beds and 40,000 outpatient visits. The environment is healthy; work standards high. An unusual opportunity for personal development and individual contributions to organizational upgrading. USCSC fringe benefits. Nondiscriminating in employment. Send application and resume to Chief of Staff, Paul F. Fletcher, M.D., VA Hospital, Chillicothe, Ohio 45601; Telephone 614-773-1141.

INTERNISTS-FAMILY PRACTITIONERS: Positions available September 1, 1978 at new VA Outpatient Clinic located in Toledo, Ohio. Salary to $40,000 plus, depending on qualifications, with Federal Civil Service benefits. An equal employment opportunity employer. Please send C.V. to Associate Chief of Staff for Ambulatory Care, VA Hospital, 2215 Fuller Road, Ann Arbor, Michigan 48105.

LOOKING FOR A POSITION?
SEEKING AN ASSOCIATE?
Contact the OSMA Placement Service
600 S. High Street, Columbus 43215
Telephone: 614/228-6971

ORTHOPEDIST WANTED: By well-established, 41-physician, multi-specialty group in Ohio. Major regional medical center including four rheumatologists. Should be board certified or eligible. Please enclose current curriculum vitae with reply to Box 824 c/o Ohio State Medical Journal.

JUNE 1978
Volume 74, Number 6

THE OHIO STATE Medical Journal



PRACTICE MANAGEMENT ISSUE

THE LIBRARY
ACQUISITIONS DIVISION
UNIVERSITY OF CALIFORNIA,
SAN FRANCISCO, CALIFORNIA 94143

LIBRARY
U.C. SAN FRANCISCO
JUN 20 1978

OCIATION

When cystitis recurs... **Bactrim fights uropathogens**



at 3 important sites

the Bactrim three-system counterattack...

① urinary tract

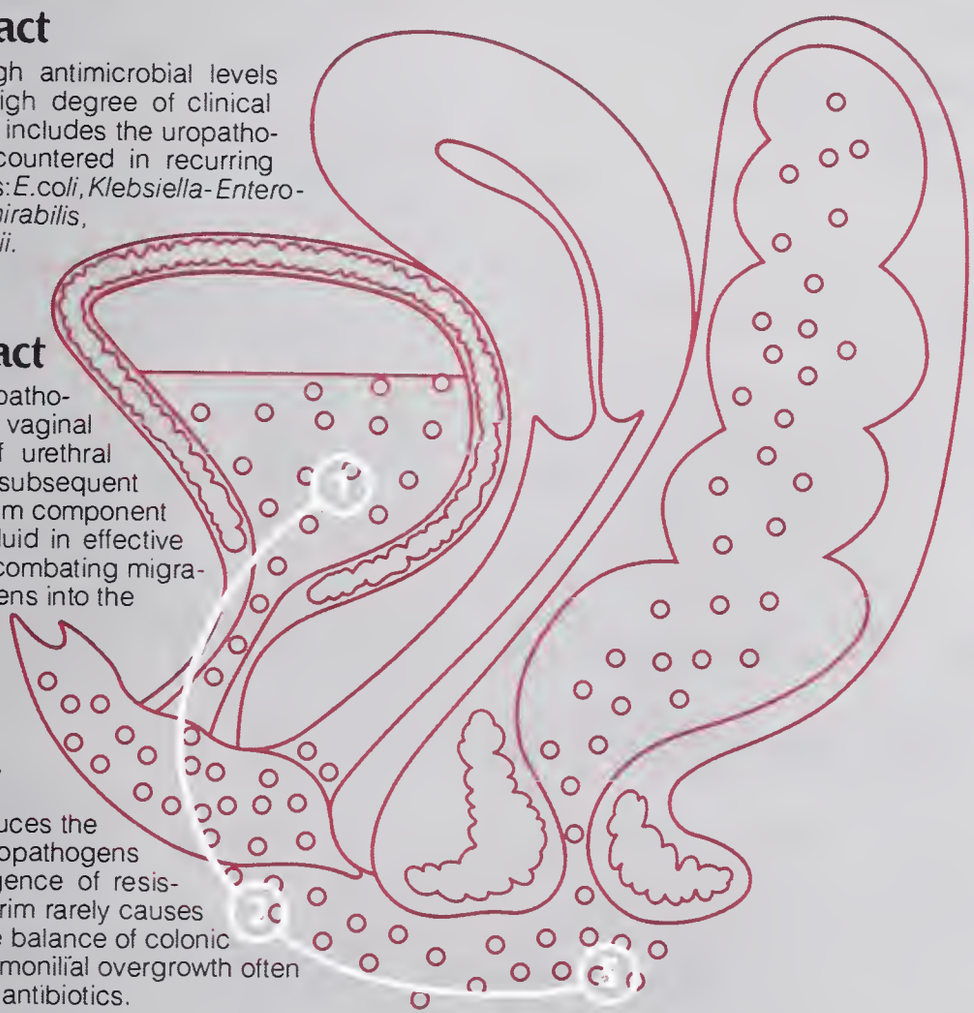
Bactrim provides high antimicrobial levels in the urine and a high degree of clinical efficacy. Its spectrum includes the uropathogens most often encountered in recurring urinary tract infections: *E.coli*, *Klebsiella-Enterobacter* and *Proteus mirabilis*, *vulgaris* and *morganii*.

② vaginal tract

Bactrim combats uropathogens colonizing the vaginal introitus, a source of urethral contamination and subsequent cystitis. Its trimethoprim component diffuses into vaginal fluid in effective concentrations, thus combating migration of urinary pathogens into the urinary system.

③ lower intestinal tract

Bactrim markedly reduces the colonic reservoir of uropathogens with negligible emergence of resistance. Moreover, Bactrim rarely causes adverse effects on the balance of colonic flora...seldom causes monilial overgrowth often associated with many antibiotics.



to clear her infection and combat reinfecting organisms

BACTRIM™ DS DOUBLE STRENGTH TABLETS

(160 mg trimethoprim and 800 mg sulfamethoxazole)

JUST ONE TABLET B.I.D. FOR 10 TO 14 DAYS

ROCHE

Please see summary of product information on next page.



When cystitis recurs...

BACTRIM™ DS DOUBLE STRENGTH TABLETS

(160 mg trimethoprim and 800 mg sulfamethoxazole)

fights uropathogens at 3 important sites

- ☐ Highly effective against most urinary invaders
- ☐ Indicated even in presence of structural abnormalities and vesicoureteral reflux (so clinically significant in children)
- ☐ Indicated in patients as young as two months of age
- ☐ Dual action minimizes microbial resistance
- ☐ Generally well tolerated, with or without food
- ☐ Easy-to-follow b.i.d. dosage schedule
- ☐ During therapy, maintain adequate fluid intake; perform frequent CBC's and urinalyses with microscopic examination
- ☐ Contraindicated during pregnancy and the nursing period, in patients hypersensitive to its components and in infants under 2 months of age

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note.* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register*, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended, therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions.* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary tract infections. Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b i d. for 10-14 days. Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment.

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage. 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100; Prescription Paks of 20. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

OSMA OFFICERS
President
JOHN J. GAUGHAN, M.D.
7911 Detroit Avenue
Cleveland 44102
President-Elect
THOMAS W. MORGAN, M.D.
P.O. Box 344
Gallipolis 45631
Past President
WILLIAM M. WELLS, M.D.
241 Hudson Avenue
Newark 43055
Secretary-Treasurer
ROBERT G. THOMAS, M.D.
630 East River Street
Elyria 44035

EDITORIAL STAFF
Consulting Medical Editor
RICHARD L. MEILING, M.D.
Managing Editor and Business Mgr.
HART F. PAGE
Executive Editor and Executive Business Manager
LINDA A. PORTERFIELD
Editorial Assistant
MARY LOU BRADY
Communications Editor
REBECCA J. DOLL
Continuing Medical Education Editor
GAIL E. DODSON
Ass't. Continuing Medical Education Editor
DAVID C. TORRENS
Federal Legislation Editor
CHARLES W. EDGAR
Field Service Editor
ROBERT E. HOLCOMB
Government Relations Editor
HERBERT E. GILLEN
Health Education Editor
ROBERT D. CLINGER
Membership Editor
KATHERINE E. WISSE
Organization Services Editor
JERRY J. CAMPBELL
State Legislation Editor
D. BRENT MULGREW, ESQ.
Ass't. State Legislation Editor
RICHARD A. AYISH

Address All Correspondence, Address Change, & Reprint Request (unless otherwise noted):
Executive Editor
The Ohio State Medical Journal
600 South High Street
Columbus, Ohio 43215
Phone: 614/228-6971

Published monthly under the direction of The Council for and by members of The Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215, a scientific society, nonprofit organization, with a definite membership for scientific and educational purposes.

1978 Subscription: $10 per year, single copy $1.50 (outside U.S. $13 and $2).

Entered as second class matter July 5, 1905, at the Post Office at Athens, Ohio, under the Act of Congress of March 3, 1879. Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918. Second-Class Postage Paid at Athens, Ohio.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertisers must conform to policies and regulations established by The Council of the Ohio State Medical Association.

Publication office: 900 East State Street, Athens, Ohio 45701.

Printed by
The Lawhead Press, Inc., Athens, Ohio

VOL. 74 JUNE 1978 NO. 6

THE OHIO STATE Medical Journal

Clinical and Scientific Article

CANCER EDUCATION SERIES: CERVICAL CANCER SCREENING PROGRAM USING PAPANICOLAOU'S STAIN TEST 412
Aileen L. MacKenzie, M.D., Columbus, and James F. Martin, M.D., Huntsville

Practice Management Articles

EVERY PHYSICIAN NEEDS THE AMERICAN MEDICAL ASSOCIATION 350
John H. Budd, M.D., Cleveland

A LOOK AT IRAs, KEOGH, AND CORPORATE RETIREMENT PLANS FOR THE PHYSICIAN 354
James T. Budden, M.B.A., and Robert C. Preston, J.D., Columbus

IMPROVED APPOINTMENT SCHEDULING AND PATIENT FLOW TECHNIQUES 358
George S. Conomikes, Marina del Rey, California

LEASING AN AUTOMOBILE: ADVANTAGES TO THE PHYSICIAN 360
Clarence E. Fox, J.D., Columbus

CHECK LIST FOR NEW OFFICE 363
Larry Girvin, Columbus

MAJOR MEDICAL AND IN-HOSPITAL INSURANCE FOR THE PHYSICIAN AND THE FAMILY 366
William A. Head, Portsmouth

THE BEST INVESTMENT DECISION YOU WILL EVER MAKE 370
Duane M. Johnson, Ph.D., Atlanta, Georgia

PRIMER ON LIFE INSURANCE 375
G. Gregory Marquis, CLU, Columbus

BILLINGS AND COLLECTIONS IN THE PHYSICIAN'S OFFICE 381
Robert S. Mauck and Michael M. Wagner, Columbus

PROPER ESTATE PLANNING FOR THE PHYSICIAN FROM THE STANDPOINT OF A PROBATE JUDGE 385
The Honorable Richard B. Metcalf, Columbus

DISABILITY INSURANCE FOR PHYSICIANS 391
J. Harry Mosher, CLU, Columbus

PHYSICIANS' OFFICE RECORDS: SOME MEDICAL-LEGAL CONSIDERATIONS 395
James E. Pohlman, J.D., Columbus

THE INSURANCE PUZZLE: ASSEMBLING THE PIECES FOR THE PHYSICIAN'S PERSONAL AND PROFESSIONAL PROTECTION 398
David L. Rader, Columbus

HOW THE PHYSICIAN LOCATES AND FINANCES HIS OFFICE 400
Robert G. Rothring, C.P.A., Cincinnati

OSMA MEMBERSHIP: YOU CAN'T AFFORD TO BE WITHOUT IT 404
Robert G. Thomas, M.D., Elyria, and Katherine E. Wisse, Columbus

INSURING HONESTY IN YOUR PRACTICE 409
Jack Walsdorf, Chicago, Illinois

Features

Colleagues in the News.....388
Legislative Update — Federal...406
New Members.....415
Obituaries 416
Journal Advertisers.....417
News 419
Classified Ads.....423

Copyright 1978. The Ohio State Medical Association. All material subject to this copyright may be photocopied for the noncommercial purpose of scientific or educational advancement.

Every Physician Needs the American Medical Association

John H. Budd, M.D.
President, American Medical Association

ALTHOUGH IT IS a familiar theme and an oft-told story, I will present some of the facts which demonstrate the value of AMA membership for a physician. Excluding from consideration the AMA's established and generally well-recognized effectiveness in medical education and accreditation at all levels, my commentary will be restricted to the area of clinical practice.

The AMA is the most influential and credible spokesman for the medical profession. The logical negotiator. The ablest responder to the blizzard of accusations, investigations, reports, legislative bills, regulations, and laws which threaten the freedom of the profession to provide what our judgment indicates as the best in medical care.

I believe that the AMA's effectiveness in this sphere is acknowledged, not only by most members of our profession, but also by our adversaries and by the media. The achievements of the American Medical Association on behalf of all physicians are many and impressive.

1976 Manpower Act

The AMA was signally successful in getting dangerous features stripped from the 1976 Manpower Act. Deleted provisions included federal standards for licensure and relicensure of physicians . . . federal control of the number and location of residencies . . . requirements that medical students either repay the capitation grants given their schools or give mandated service in underserved areas as determined by federal bureaucrats . . . and requirement that all residency programs be affiliated with a medical school. These victories were an important protection of the freedom of professional education and practice.

Although the mandatory service requirement was stricken from the federal law, it is being pushed in several states. For example, Massachusetts promulgated regulations that require students at a state-supported medical school to practice in the state for one year or pay $8,000 to the state. Other states have introduced similar bills.

Trips to Federal Court

On several occasions, when both discussion with the Department of Health, Education, and Welfare and legislative effort fail, the AMA has gone to federal court. True, we do not always win; but there have been notable victories such as that resulting in withdrawal of the utilization review guidelines which had mandated preadmission certification of hospital patients.

Professional Liability

Although the medical professional liability problem has not been solved, significant improvement has been accomplished, much of it through AMA efforts. One such improvement is the legal climate. This change is due in large degree to the adoption of a total of some 300 state laws following models developed by the AMA's legal department. Every state in the Union has adopted some of these laws.

In addition, the American Medical Assurance Company (AMACO) is providing reinsurance backup to physician-operated insurance companies organized by state medical associations. AMACO was established by the AMA and was funded by $5 million of the Association's money.

Finally, medical malpractice insurance premiums appear to be leveling off and even dropping in some states. For example, Aetna announced premium reductions of 2% to 5% in six states, and St. Paul declared reductions of 9% to 26% in 17 states. Not a complete triumph, but a significant and promising step.

Keogh Plan

An undeniable cash benefit for the individual physician is the Keogh Plan, brought to pass almost exclusively through AMA effort. Let me illustrate the tax savings.

Dr. Budd, Cleveland, President, American Medical Association; family practitioner, Cleveland.

The physician in the 40% bracket, who sets aside up to $7,500 a year on a tax-deferred basis, can postpone $3,000 in tax (40% of $7,500). Assuming a lower tax bracket upon retirement— say 20%— due to less earnings, increased deductions, and increased exemptions, the tax on each $7,500 now reclaimed would be $1,500. This amounts to a savings for each year of six times the AMA dues.

Medicare

Although Medicare was enacted over our objections (and they were valid, not self-serving), physicians are still free to practice medicine pretty much as we desire. Such practice includes fee-for-service . . . no requirement to accept assignment . . . direct billing at our option. Even though percentile fee reduction, delay in reimbursement, and frustrating paper work admittedly exist, the advantages mentioned are important and were largely the result of AMA action.

Benefit to All

American Medical Association membership is made up of physicians. It represents and speaks for physicians in all areas of medicine . . . those in patient care, solo, group, or institutional . . . teachers . . . researchers . . . administrators . . . medical students . . . interns and residents. The latter comprise the fastest growing section, totaling over 25,000 members.

Unfortunately, it is true that a large number of physicians do not realize the magnitude of the AMA's commitment to our public and professional obligations; and a large number also are unmindful of what they have already received in benefits. Many of the AMA's contributions to medical education, public health, environmental melioration, medical morality, hospital relations, adequate reimbursement, and legislation in the public interest are taken for granted by the public, the media, and many of the profession.

Unity

Finally, the responsiveness I mentioned at the outset cannot be one-sided. We need more than simple solidarity in thought and action. These efforts and programs, besides being real and important, are expensive and require financial support. The biggest source of AMA revenue is membership dues. Remember that because the AMA is a federation of state associations, it cannot act independently for just its own members. Therefore, while the dues-payers foot the bills, **all physicians benefit.**

Besides contributions to the quality, understanding, and delivery of medical care and to medical education in all its phases— school, graduate, postgraduate, and continuing— a preeminent blessing is our continued professional status in a world where fewer and fewer physicians are free. The American Medical Association is the chief protector of that freedom and the best bulwark against unreasonable intrusion and change.

Of this I feel strongly . . . I hope you, too, will agree.

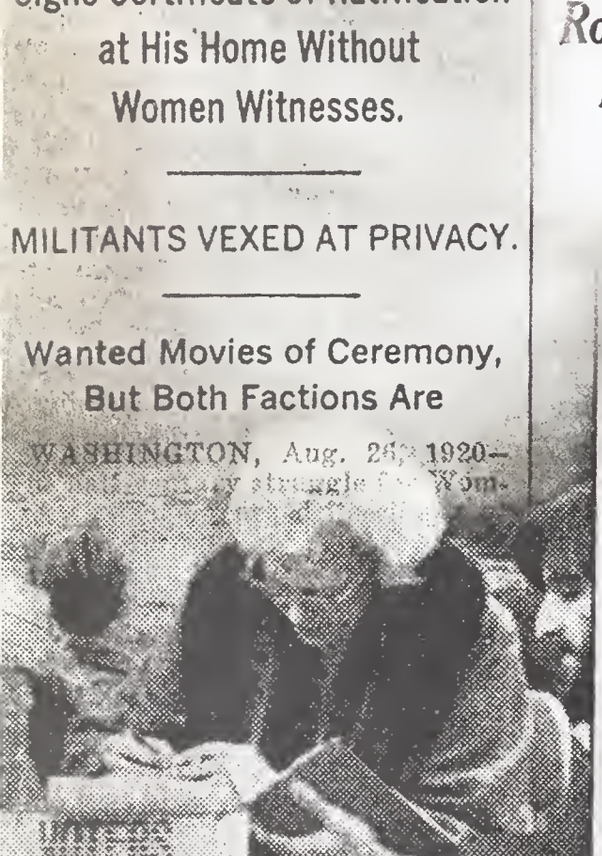


COLBY PROCLAIMS WOMAN SUFFRAGE

Signs Certificate of Ratification at His Home Without Women Witnesses.

MILITANTS VEXED AT PRIVACY.

Wanted Movies of Ceremony, But Both Factions Are



WASHINGTON, Aug. 26, 1920—

Social Security Bill Is Signed; Gives Pensions to Aged, Jobl

Roosevelt Approves Message Intended to Benefit 30,000 Persons When States Adopt Cooperating Laws–He Ca the Measure 'Cornerstone' of His Economic Program

WASHINGTON, Aug. 14, 1
The Social Security Bill, prov a broad program of unemploy insurance and old age pen and counted upon to benefit 20,000,000 persons, became la day when it was signed by P dent Roosevelt in the preser those chiefly responsible for ting it through Congress.

Mr. Roosevelt called the me "the cornerstone in a stru which is being built to m is complete ri to

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today 94 to 0 and sent to

TRUMAN CLOSES TED NATIONS CONFEREN ITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

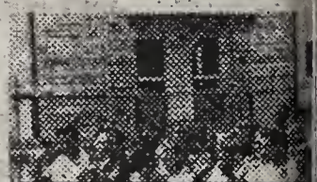
"Oh, what a great day this can be in history!"

Just before the plenary session

IGNE

the Draf Ends No

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the



PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA
THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION
1155 FIFTEENTH ST., N. W. WASHINGTON, D. C. 20005

A Look at IRAs, Keogh, and Corporate Retirement Plans for the Physician

James T. Budden, M.B.A.
Robert C. Preston, J.D.

AS AN INTEGRAL PART of his investment program, almost every physician should have some type of tax-sheltered savings plan. Saving tax-deductible dollars and having those dollars earn tax-free interest or dividends for retirement, or family protection in the event of premature death, make such a program imperative for your personal financial planning.

What type of tax-sheltered savings plan is best for you? Should you consider an Individual Retirement Account (IRA) for yourself and your spouse, a Keogh Plan if you are self-employed or a partner in a group practice, or a qualified pension and/or profit-sharing plan if your practice is incorporated. Obviously, an exhaustive comparison applied to your situation can only be accomplished after consultation with your tax and financial advisors; however, in the Table, we attempt to compare some of the major features of these programs.

All qualified retirement plans are regulated by the Internal Revenue Service and the Department of Labor under guidelines established by the Employee Retirement Income Security Act of 1974 (ERISA). Because there are several hundred thousand retirement plans affecting vast numbers of employees in the United States, ERISA is rapidly becoming as important a piece of legislation as Social Security. The Table may help you to grasp the very broad, general concepts behind each type of program. It may enable you to ask the appropriate questions necessary to arrive at a plan which is suited not only to your current income and spending habits, but also to your temperament and retirement needs. If you already have a retirement plan, this article may help you to review it for suitability or the need for additional planning.

Age and Income

The appropriateness of your selection of a plan depends upon a number of factors including your age, the amount of income from private practice and from other sources, the level of personal and family spending requirements, the cost of including your employees in the plan, and your present or future commitments to other investment programs. Handled properly, a retirement program for your employees is a direct incentive. In fact, employees may expect a retirement program since it is frequently provided at other professional offices and hospitals.

Normally, the two major considerations are age and practice income: (1) How many years do you have to accumulate funds for retirement? (2) How much of your current income can you afford to set aside? Defined benefit rules generally require that the plan be in existence for a ten-year period before you start drawing the projected benefits. If your retirement is less than ten years away, such a plan may not be meaningful. The Keogh Plan may also be unacceptable if you plan to practice beyond age 70 years, at which time benefits under that plan must have commenced distribution.

Benefit Plans

Qualified retirement plans are broken into two major categories: defined-contribution and defined-benefit plans. The allowable contributions to defined-contribution plans are based upon a percentage of the total compensation of all participating employees. Up to 15% of compensation can be contributed to a defined-contribution profit-sharing plan and up to 25% of compensation to a defined-contribution pension plan or a combination of profit-sharing and pension. However, not more than $30,050 may be contributed for 1978. This figure will be adjusted annually to keep up with inflation. There is no projected or guaranteed retirement benefit in these types

Mr. Budden, Columbus, Director, Professional Investment Management Division, Consolidated Business Services, Columbus; and former bank trust officer.

Mr. Preston, Columbus, a partner in the law firm of Robins, Preston & Beckett Co., L.P.A., is a frequent author and lecturer on matters of corporations, financial planning, and tax laws.

Comparison of Qualified IRA, Keogh, and Corporate Retirement Plans

	IRA	KEOGH PLAN	CORPORATE PLAN
Eligibility to Participate	Any person with earned income who is not otherwise covered by a qualified retirement plan.	All employees with three years of service or less (irrespective of age) who work at least 1,000 hours yearly must be included.	Minimum age requirements can be imposed up to 25 years of age and a waiting period up to one year can limit employee participation.
Maximum Contributions	Lessor of $1,500 or 15% of earned income. May establish a separate account for non-working spouse. In such case, the aggregate deduction for both is the lesser of 15% of earned income, $1,750, or twice the amount contributed to IRA of the spouse for whose benefit the smaller amount was contributed.	Insofar as "10%" owner is concerned, the maximum contribution is 15% of net professional practice income or $7,500, whichever is less. Under certain circumstances in a defined-benefit plan, contributions in excess of $7,500 can be made.	In a defined contribution (ie, profit-sharing or money-purchase pension plan, or a combination of the two) up to 25% of participant compensation. In a defined-benefit plan, no dollar limits except that amounts cannot be contributed to fund an annual retirement income of more than $75,000 (adjusted by cost-of-living increases).
Integration With Social Security	No	Not permitted in a defined-benefit plan and permitted in a defined-contribution plan only if contributions on behalf of "10% or more" owners do not exceed one-third of total "employer" contributions.	Available, in general. Enables cost economies by lower contributions for employees who do not make more than the Social Security Wage Ceiling.
Loans From Plan to Participants	No	Not permitted without tax penalty.	Permissible within prescribed limits, thereby giving participant access to funds in event of financial need.
Distribution of Benefits	In general, must start between age 59½ and 70½ years.	Same as IRA.	Generally, no set age requirements and no compulsory retirement with broad variations which allow early distribution or deferral of distribution beyond normal retirement.
Early Receipt of Benefits by Professionals (before normal or early retirement date, death, or permanent disability)	Distribution prior to age 59½ years not permitted. Same as Keogh.	Distribution prior to age 59½ years not permitted. If made, a 10% penalty tax and a five-year ban on participation in a Keogh Plan may result.	Generally, no penalties for pre-retirement payments or withdrawals.
Forfeiture of Amounts Contributed by Employee	Non-forfeitable at all times.	An employee participant's interest must be non-forfeitable at all times.	Generally, a participant's interest may be subject to forfeitures if they quit before attaining certain lengths of employment as prescribed by statute.
Allocation of Forfeitures to Professional's Account	No	No	Yes, thereby increasing the professional's retirement plan account balances by the amount of forfeitures of employees who terminate their employment early, or may be used to reduce contributions.
Income Taxation When Benefits Are Distributed	Taxable at ordinary income rates—no special ten-year-forward averaging available.	Employer-related installment payments of benefits are taxable as ordinary income to the professional, although more favorable annuity treatment may be allowed. Under a lump-sum distribution at age 59½ years or older while actively employed, death, disability, or retirement, long-term capital gain is accorded payment in proportion to the ratio of pre-1974 years of participation to all years of participation with remaining payments taxed as ordinary income, but entitled to a special ten-year income averaging treatment which may substantially lower tax to below ordinary rates.	
Income-Tax-Free $5,000 Death Benefit	No	No	Yes, $5,000 of distribution not income taxable to beneficiary.
Estate Taxation of Death Benefits Payable to Named Beneficiaries	Generally, not subject to Federal Estate Taxes to the extent distributions are attributable to company contributions and except for certain lump-sum distributions.		
Additional Voluntary Contributions to Plan by Participant	No	Voluntary contributions limited to the lesser of $2,500 per year or 10% of income and permitted only if a common-law employee other than professional is also covered.	Voluntary contributions generally permitted of up to 10% of compensation.

of plans, and the benefit a participant will be entitled to on retirement is based solely upon the total contributions made on his behalf and his allocable share of the earnings, losses, and forfeitures on those contributions.

On the other hand, contributions to a defined-benefit plan are not based upon a percentage of compensation but rather on a projected retirement benefit. The first step in designing a defined-benefit plan is to decide on the annual retirement income desired. For example, "defined benefit" might equal 50% of your average compensation. Then each year, you will contribute enough money so that when you retire, you will have a fund large enough to pay that benefit. The older the physician, the fewer years he has until retirement, and the more money that must be put away each year to accumulate the fund. On the other hand, the younger you are, the more time until retirement, and the smaller the annual contribution.

The maximum contribution for a Keogh Plan is generally $7,500 (15% of $50,000), but may be slightly higher in a defined-benefit plan. An incorporated physician making $50,000 could contribute $12,500 to a defined-contribution pension and/or profit-sharing plan.

The Older Physician

An older physician who wants to maximize the amount of his contributions to a retirement plan should consider the advantages of a defined-benefit plan. For example, a 55-year-old physician who wants to have the maximum pension payout of $84,525 a year (increased to $90,151 for 1978) could set aside over $71,000 each year from now until retirement in ten years. He could do this, provided he is drawing a salary of at least $84,525 a year and has enough income to afford to make the maximum contribution. The older the physician, the less time to retirement; and, consequently, the more money that has to be put away each year to build up the required fund. Generally, the age level at which higher contributions can be made to a defined-benefit plan as opposed to a defined-contribution plan is 42 years. So if maximum contributions are the goal, the physician past age 42 years should look at a defined-benefit plan.

Making the Decision

The fact that the establishment of a retirement program is a major, lifetime, investment decision on a physician's part emphasizes the importance of the selection and design of the plan. Once the selection is made, it is often very difficult to change directions. Although the selection process is time consuming, it is certainly time well spent when weighed against the years of involvement. Your advisors should assist you in visualizing what the alternatives will mean several years from now. For example, how might your personal cash needs change over the years (ie, children in college, vacation plans, changes in practice income caused by competition or governmental influence)? Make certain that your retirement plan has sufficient flexibilities to allow you to react to the unexpected.

Often it is the variety of options available which dictate the type of plan to be selected, and, in turn, the form of practice entity, such as solo, partnership, or corporation. Does the plan allow you to choose how your funds will be invested? How wide is that choice? Can you determine the conservatism or speculativeness of the investment decisions or is that choice limited by the investment products offered in a certain type of plan? A thorough discussion of the types of investment programs available in retirement plans is outside of the scope of this article; however, you should be aware that most IRAs and Keogh Plans and many bank-trusteed corporate plans severely limit your choices. Investment discretion should be thoroughly investigated prior to deciding who will administer your plan.

The ability to select your own investment becomes a far more comfortable option to accept if you are working with an investment advisor or stockbroker in whom you have confidence. Your advisor should have an appreciation for the fiduciary standards of ERISA, which must be met in dealing with your own and your employees' qualified retirement funds. It should be noted that most registered investment advisors and stockbrokers are aware of these ERISA standards through their own corporate and internal education programs. You can work with your advisor better if you do not set impossible goals for performance. Unusually large rewards often go hand in hand with unusually high risks. High risks imply higher chance of failure leading to mutual dissatisfaction. There are years when a "break even" performance would be considered excellent. If you had a $100,000 single deposit with no further addition and it grew at a compound rate of 7%, it would be worth $197,000 in ten years, $387,000 in 20 years, and $761,000 in 30 years. At a 15% return, that same deposit would be $405,000 in ten years, $1,637,000 in 20 years, and $6,621,000 in 30 years. From this little exercise, it becomes obvious that there would be many more millionaires than there are if 15% per annum was a normal, sustainable rate of annual return.

Investments

There are some general thoughts that you might consider about investing within your retirement program. The contributions to your plan are tax deductible. As such, high-risk investments, which might be worth the risk outside the retirement plan, are even riskier within the plan because you cannot deduct any losses which might be incurred. Secondly, you should become aware of the "magic" of compound interest. Eliminating current taxes, as the retirement plan does, you can figure how long it takes money to double by dividing any interest rate into the financial constant 72. For example, a bond paying 6% doubles your investment in 12 years ($72 \div 6 = 12$). Whereas high-income-yielding investments may not be a desirable part of your personal, taxable investment program due to the high unearned income-tax rates, such an investment in a nontaxable retirement plan may be extremely desirable. In fact, it may well form the basis of

the plan's investment portfolio. Sometimes the best investment in your plan may be a savings account or certificate of deposit, sometimes it is stock, and sometimes it may be a good quality bond.

Plans can be written to allow you to select your own trustee, administrators, and investment advisors. This flexibility allows you to be aware of what is happening to your plans and to take part in adopting and executing your investment policy. On the other hand, it can be very frustrating to turn your retirement plan over to someone who does not keep you advised or who makes you feel that you are imposing upon him when you request information. After all, it is your money; and you should be dealing with persons who feel that your plan and your inquiries are important.

Among the more popular options available in retirement-plan programs are the participant's loan provisions. ERISA permits you to borrow funds against your own retirement account for personal use. Caution must be exercised so as not to abuse these loan privileges. The loan must be on a "commercially feasible" basis with a competitive rate of interest and a definite repayment schedule.

Consider the pros and cons of using part of your retirement funds to purchase a life insurance policy on your life to assist in creating personal pre-retirement death benefits and as a means of supplementing your personal insurance program. It is possible in Keogh Plans, and to a greater extent in corporate plans, to have your life insurance premiums paid on a partially tax-free basis, which may assist you in your family-security planning.

Summary

A quick look at the Table and the comments in this article make it graphically clear that greater savings capabilities, controls, and flexibilities are obtained in corporate retirement plans. This slant in favor of corporate plans, as well as the many other benefits available only to corporate employees and not to those self-employed, has existed in our tax laws for many years. Such distinctions are more historic than logic. Nevertheless, they are facts of life which make it necessary to consider incorporation.

This article is certainly not intended as a primer or do-it-yourself course but, hopefully, has provided you with some insight into the importance of your decision regarding tax-favored savings programs. There really are a number of options available in these plans. In a large part, your success in reaching your savings expectation depends upon the time and effort which you and your advisors spend in analyzing your personal needs and in selecting the best available options to accomplish these goals.

In closing, it should be noted that your retirement plan is an integral part of your estate planning program. As such, perhaps you will want to review your estate when you establish your retirement plan and again in the coming years, at intervals which you and your advisors deem appropriate, as your plan grows and as your personal situations change.

This year . . . the chances of your being seriously disabled are far greater than death.

THIS CHART SHOWS JUST HOW MUCH GREATER.

CHANCES OF DISABILITY VS. DEATH	
If you are age:	A disability of 90 days or longer is this much more likely to occur than death this year
22	7½ TIMES GREATER
32	6½ TIMES GREATER
37	5½ TIMES GREATER
42	4 TIMES GREATER
47	3½ TIMES GREATER
52	2½ TIMES GREATER
62	2 TIMES GREATER

Source: The National Underwriter Company, 420 E. 4th St., Cincinnati, Ohio 45202

When disability occurs, will your protection be adequate?

To be sure you have an income when you're disabled, enroll in . . .
THE DISABILITY INCOME PROTECTION PLAN which your Ohio State Medical Association co-sponsors with many local medical societies. You may apply for benefits up to $500 weekly.

CONTACT:

TURNER AND SHEPARD INC.

Columbus, Ohio 43215	17 South High Street	Phone (614) 228-6115
Akron, Ohio 44313	3090 West Market Street	Phone (216) 434-5000
Cincinnati, Ohio 45241	4015 Executive Park Drive	Phone (513) 563-4220
Cleveland, Ohio 44134	1440 Snow Road	Phone (216) 741-4466
Toledo, Ohio 43606	3450 West Central Avenue	Phone (419) 535-0616

Improved Appointment Scheduling and Patient Flow Techniques

George S. Conomikes

EVERY DAY, MOST WORKING Americans go to their jobs with some sort of an accomplishment schedule. Bricklayers know that they will lay between 400 and 600 bricks; truck drivers will log 300 miles; salespeople will make a certain number of calls; and executives will extinguish a predictable number of fires. (The latter is called "problem solving"!) But the lonely physician doesn't know what's in store for him. He just hopes today won't be as bad as yesterday— and his hopes usually are shattered.

Of all the complaints our firm hears from all concerned parties— physicians, medical assistants, nurses, patients, and even the relatives and friends of the foregoing — the doctor's appointment schedule heads the list.

Medical World News recently reported a survey of 7,787 patients undertaken by the University of Chicago Center for Health Administrative Studies. This survey pointed out that "time spent in the waiting room" made 28% of the respondents unhappy. If patients had to wait more than 30 minutes, the "unhappiness threshold" doubled to 60%.

The Telephone

In defining practice management problems, which this firm has undertaken with thousands of physicians and their office staffs, appointment scheduling is at the top of the list. It comes out either ahead of, or just behind, the telephone as the bane of the practice.

One reason for the appointment scheduling problem is the telephone. If the phone is too busy, is improperly managed, or calls are not handled systematically, then it is difficult to maintain a good appointment-scheduling system.

Depending upon your specialty and your communication with patients, (ie, encouraging or inhibiting routine patient phone calls), 40% to 70% of incoming phone calls result in an appointment. Therefore, the most important ingredient in a good scheduling system is a telephone system that helps you determine **how urgent** the calling patient's problem is. Physicians who have well-organized practices don't leave this to chance, and they don't rely on the memory pattern of the telephone receptionist. After all, on a busy Monday or Friday afternoon, she could be so preoccupied and tired that her computer-bank mind draws a blank.

The way to help yourself, and your telephone receptionist, is to develop a list of patients' problems by levels of urgency:

Emergencies (define them):
What should be done with the patient?

Urgencies (define them):
When should the patient be seen?

Routines (define them):
When should the patient be seen?

Almost everyone knows what an emergency is and what to do about it, and just about everyone knows what a routine case is and what to do about it. However, we have found that a physician's appointment book is often filled up with routine appointments. This is what keeps out sick and urgent patients.

When a physician and his medical assistants tell me that the doctor is booked for the next three weeks, or six weeks, or nine weeks, I can only respond by saying that he's hurting himself. This is because in the next three, six, or nine weeks, a significant number of his patients are going to be just plain sick—not emergencies—just plain sick.

Work-in Rate

These sick patients— whom we shall call urgent because they are not critical— need to be seen relatively soon, but they are the ones who have to fight to get an appointment. Why? Because nobody has kept the data on

Mr. Conomikes is President of Conomikes Associates, Inc., a medical practice management consulting firm based in Marina del Rey, California.

what the physician's **work-in-rate** is. By asking your appointment scheduler (who also may be your telephone receptionist) to keep tab on your emergencies and urgent cases, you can determine with some reasonable accuracy how many "openings" to leave in your appointment-scheduling system. These openings are for your predictable three, four, five, or ten emergencies and urgent cases that must be worked in every day.

Your receptionist tells me her biggest appointment-scheduling problems are the emergencies and those sick patients who are unwilling to wait. You physicians tell me that your most interesting patients are the emergencies and the sick patients— not the routine, "well" patients. So, your routine, well patients and your appointment scheduler are working at odds against you because all of you are against a filled-up appointment schedule and against the sick-urgent patient who's trying to get an appointment.

Summary

Solution: Get the data on work-ins. Open up your filled-up appointment book.

But set the rules with your appointment scheduler. She wants you to set the rules! If you don't work with her on it, you have no control over your day's work. And tomorrow will be like today— you'll envy the bricklayer, the truck driver, the salesman, and everybody else when, in fact, they envy you because they don't know about your scheduling nightmare.

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

OHIO OFFICES:

CINCINNATI: Raam 700, 3333 Vine Street, (513) 751-0657, L. A. Flaherty

CLEVELAND: Suite 106, 23360 Chagrin Baulevard, Beachwood 44122, (216) 464-9950

A. C. Spath, Jr., R. A. Zimmerman

COLUMBUS: 1989 West 5th Ave., (614) 486-3939, J. E. Hansel

TOLEDO: 1011 Sandusky St., Suite H, P.O. Box 331, Perrysburg 43551, (419) 874-8080, R. E. Stallter

THE WENDT-BRISTOL COMPANY

1159 DUBLIN ROAD

COLUMBUS, OHIO 43215

614/486-9411

MEDICAL/SURGICAL PRODUCTS

LABORATORY PRODUCTS

SPECIALTY PRODUCTS

PHARMACEUTICALS

PATIENT AIDS

INSTRUMENTS

FURNITURE

Leasing an Automobile: Advantages to the Physician

Clarence E. Fox, J.D.

WHY LEASE? HOW DO I BENEFIT? These questions have been asked thousands of times. The answer is there are different benefits for different people. Remember, benefits can be subjective as well as objective.

Personal Use

Consider the case of the lease where there is no business-connected tax advantage. Many young professionals and paraprofessionals, both male and female, have turned to leasing because little or no down payment is necessary. As the residual value of the automobile is taken into consideration, the payment generally will be lower than mortgage-type financing. However, you must have a very good credit history or exceptional expectations to qualify for a lease if you are under age 25 years. For example, due to their future potential, senior medical students are often solicited by leasing companies.

All of these facts apply to the practicing physician. He/she may wish to use the money that normally would be tied up in a car to better advantage— such as a trip, a boat, or an investment. Leasing gives the physician a choice if he/she does not want to have $6,000 to $15,000 invested in a car.

Use in Practice

Taxwise, leasing has many advantages for those in and near the 50% bracket who use their cars in their practices. Generally, the Internal Revenue Service will accept a 70% to 90% business usage. This amount includes lease payments, sales tax, insurance, gasoline. maintenance, parking, and other expenses. Leasing records are simple, and your monthly check is your receipt. Also, you do not have to keep a record of the depreciation on your automobile or of any possible increase in the investment if you were to sell the car.

Types of Leases

Basically, there are two types of leases: the open-end lease and the closed-end lease. Built into the open-end lease is an estimate of the car's worth at the end of the lease, which the customer guarantees. This type of lease entails considerable risk as the automobile may not be worth the projected value. It may have been involved in a wreck and, therefore, its value would be diminished; or the market may have turned against that particular model.

The closed-end lease is the risk-free option. You simply walk away from the car at the end of the lease. You are responsible only for damage to the car— no guaranty of value whatsoever.

The lease developed for the Ohio State Medical Association eight years ago is unique, giving the lessee the best of both worlds. If you desire, you can purchase your leased automobile at a predetermined price, which you know at the beginning of the lease; or you can just return the car. This is a closed-end lease with an option.

Convenience

Convenience is one of the very important criteria of leasing automobiles. A company can complete an entire lease— signed, sealed, and delivered— in less than an hour. Most of the work is done on the telephone. In addition, our firm delivers automobiles throughout Ohio to physicians whose first glimpse of the car often is when it is driven up the driveway.

How much is convenience worth? Many physicians do not like to take the time required to shop for a car, and they often resent the semiannual pilgrimage to the automobile dealership. Leasing presents a "smorgasbord on wheels," where a car can be ordered anytime at your leisure. At the other end of the spectrum, car "buffs" have a field day looking and comparing cars by means of catalogues. For example, our brochure lists and itemizes the prices for 58 American and foreign cars.

Summary

Finally, your lease company has a great interest in your car— they own it and usually will get it back when you are through with it. A good leasing company will help you when you have service problems, will go to bat with the factory for you, and will oversee repairs. Perhaps most important, a good leasing company will assist you in changing cars if you desire, the entire transaction costing less than if you owned the car.

How leasing companies make money is no secret. They can buy the automobile for less than you can and can borrow money at wholesale rates. Between the two, there is a reasonable profit.

For the average physician, leasing is mostly tax deductible, it offers complete freedom of choice, and is very convenient. It never costs more than ownership and sometimes substantially less.

Mr. Fox is General Manager and Counsel for Immke Circle Leasing, Inc., Columbus, Ohio.

A Medical Breakthrough!

The Paperwork Transplant

Paperwork. It's become one of the most time consuming and costly jobs in medicine. But the computer terminal you see here is starting to change all that. With it in your office, one of your staff can "transplant" your paperwork for processing through the Nationwide Professional Services central computer facility.



A successful operation is the result of finely honed surgical instruments in the hands of a skilled surgeon, supported by an experienced team.

Now, Nationwide Professional Services Corporation has applied this proven formula to the task of removing the burden of paperwork from your office.

Through this terminal comes a finely honed accounts receivable program. Placed in the hands of your staff and supported by the service and experience of the Nationwide organization, the paperwork transplant is easily performed each day simply by "typing" in normal patient information, services provided and applicable charges.

Call 614/227-6995 or return this coupon for the full story on how your cash flow can improve.

NPSC

NATIONWIDE PROFESSIONAL SERVICES CORPORATION

To: Nationwide Professional Services Corporation
One Nationwide Plaza
Columbus, OH 43216

Please call me for an appointment at my convenience.

DOCTOR_____

ADDRESS_____

CITY_____ STATE_____

ZIP_____ TELEPHONE_____

Eastern Mediterranean

Air/Sea Cruise





Departing Cincinnati and Cleveland on October 13
Returning October 26, 1978

Sail from Athens to Turkey, Egypt, Israel and the Greek Isles.

Discover democracy's symbolic birthplace in Athens . . . biblical Ephesus a great architectural wonder . . . exotic Istanbul filled with mosques, minarets and bright bazaars . . . charming Mykonos and intriguing Crete, both unforgettable.

Visit Alexandria, gateway to Cairo, Egypt's city of the Sphinx and Pyramids . . . Haifa, entrance to the biblical city of Jerusalem . . . and Rhodes with its idyllic landscape.

Your ship will be prestigious Sun Line's flagship, the SS STELLA SOLARIS that is nothing less than elegant. The staterooms are spacious, lounges are decorated with soft velvet and genuine leather. The dining room is comfortably large offering tables set with fine crystal, monogrammed china and fresh flowers.

There's even more. Energetic deck games, two swimming pools, sauna and gymnasium. Restful lounges, a library and sunny promenades for relaxing. Fine evening entertainment, first-run movies and deserted moonlit decks.

Come sail the sun-sparkled Mediterranean with us for two weeks. From as low as $1598 enjoy round-trip flights with 70 pound luggage allowance, spacious accommodations aboard ship, three superb meals each day plus mid-morning bouillon and late night buffet, transfers, INTRAV Travel Director and Cruise Director.

A Non-Regimented
INTRAV®
Deluxe Adventure

Send to: Ohio State Medical Association
600 High Street
Columbus, Ohio 43215

Enclosed is my check for $ _____ ($100 per person) as deposit.

Names _____

Address _____

City _____ State _____ Zip _____

Area Code _____ Phone _____

Space Strictly Limited—Make Reservations Now

Check List for New Office

Larry Girvin

1. Typewriter
_____*Carriage capacity
_____*Manual versus electric
_____*Type style
_____*Permanent versus one-time (mylar) ribbon
_____*Color
_____*Electrical connect provision
_____*Size and make (per job requirement)

2. Adding Machine
_____*Full keyboard versus ten key
_____*Numeral capacity
_____*Electric versus manual
_____*Color
_____*Size and make (per job requirement)
_____*Electrical connect provision

3. Dictating and Transcribing
_____*Use of outside service
_____*Lease or buy
_____*Model, make (per job requirements)
_____*Color
_____*Electrical, battery, both
_____*Record, time capacity
_____*Portability

4. Accounts Receivable System
_____*Fee ticket (design)
_____*Ledger card (full versus half)
_____*Posting system
_____*Ledger card file tray
_____*Alpha dividers (25, 50, 100, or more)
_____*Delinquent follow-up procedure
_____*"OUT" cards
_____*Type or handwritten
_____*Copy machine

5. Medical History Filing System
_____*Filing (drawer versus open-shelf)
_____*Locking capability
_____*Alpha dividers (25, 50, 100, or more)
_____*Color-coding system
_____*Folders: end or top-tab
_____*Name labels
_____*Patient envelopes
_____*"OUT" cards
_____*History record form and follow-up form
_____*Ob/Gyn form
_____*Patient registration form
_____*Clipboards (size)
_____*Shelf or drawer dividers

6. Petty Cash
_____*Change-making
_____*Small purchase account
_____*Voucher forms

7. Accounts Payable
_____*Recordkeeping system
_____*Two files (paid and unpaid)
_____*Expanding alpha file

8. Banking
_____*Establish business checking account
_____*Check system (regular versus pegboard)

9. Insurance Forms and Rate Books
_____*Blue Shield (forms)
_____*Worker's Compensation
_____*Major carrier in area

10. Rubber Stamps
_____*Name and address stamp
_____*Bank deposit stamp
_____*Allergic stamp
_____*Collection stamp
_____*Date stamp
_____*Ob/Gyn stamp

11. Patient Recall System
_____*Monthly divider
_____*Tub file
_____*Printed form

12. Business Miscellaneous Items
_____*Doctor "In and Out" sign
_____*Want Book
_____*Dictating disks or belts
_____*Cash box for petty cash

13. Stationery Supplies
_____*Scotch tape
_____*Paper clips
_____*Rubber bands
_____*Ballpoint pens (black & red)
_____*Stapler and staples
_____*Telephone directory (desk model)
_____*Typewriter eraser or corrective paper
_____*Letter opener
_____*Stamp pads (black, red)
_____*Ruler
_____*Liquid marking pen (black, red)
_____*Bulletin board "push pins"
_____*Dictionary (Medical, Standard), medium print
_____*Scissors
_____*Receipt book
_____*Upright file for desk
_____*Appointment books (office and doctor)
_____*Color "tab" markers
_____*Carbon paper
_____*Marking pencils (red, black)

14. Cost Control System
_____*Hospital/house-call control system
_____*Expense control system
_____*Cost control system (drugs)

15. Laboratory
_____*Contact professional "outside" laboratory either local or mail-type
+ Lab receptacles
+ Fee structure
_____*Distilled water (contact company)
+ Five-gallon jug, plus rack
+ Hand-bulb spicket
_____*Coffee pot, cups, supplies
_____*Refrigerator

16. Employees
_____*Perform nursing duties
+ R.N., L.P.N., aide, technician, trainee
_____*Secretary
+ Aide, previous experience, trainee
_____*Laboratory/X-ray technician
+ Registered, previous experience, trainee
_____*General information
+ Starting date
+ Uniform
+ Social Security
+ Number of dependents
+ Application in file

Mr. Girvin, Management Consultant, Professional Practice Management, Columbus.

17. **Fee Structure**
_____*Medical
_____*Laboratory
_____*General business (ie, insurance reports, bookkeeping charge)
_____*Surgical
_____*Surgical assists

18. **RX Blanks (order from local pharmacy or doctor purchase)**
_____*⅓ padded
_____*⅔ loose
_____*Exam room holder
_____*Leather carrying case
_____*Narcotic number
_____*Style and color

19. **Printing**
_____*Letterhead stationery (full- & half-sized)
_____*Envelopes
_____*Name cards
_____*Announcement
_____*Recall form
_____*Record release form
_____*Fee tickets
_____*Return to work & school forms

20. **Telephone Answering**
_____*7 day/24-hour service
_____*Local, service only
_____*Medical society/commercial
_____*Direct line or telephone listing

21. **Laundry**
_____*Towels (exam, lab, & toilet)
_____*Drape sheets
_____*Doctor coats
_____*Cups & dispenser

22. **Diaper Service**
_____*Pediatrics

23. **Communications**
_____*Telephone (wall, desk)
+ Nine-foot receiver cords
+ Call diverter
+ Pushbutton
+ Dial (dial card, touch-tone)
+ Business line number(s)
Make inquiry of phone company as to closing date for directory listing.
+ Rotary lines
+ Unlisted line
+ Directory listing
+ Intercom feature
_____*Determine procedure for answering telephone
_____*Pharmacy direct lines
_____*Intercom (commercial)
+ Station units
+ Command units
+ Call origination necessity
_____*Music
+ AM, FM, records, tape (commercial)
+ Number of speakers

24. **Janitorial Service**
_____*Initial office cleaning prior to occupancy
_____*Independent versus commercial
_____*Supplies
+ Waxes, floor and furniture
+ Ammonia cleaner
+ Window cleaner
+ Cleanser
+ Dust and polishing cloths
+ Sponges
+ Salt or calcium chloride
+ Disinfectant
_____*Equipment
+ Floor buffer
+ Vacuum cleaner
+ Snow shovel
+ Broom
+ Salt

25. **Snow Removal**
_____*Commercial, independent, or self

26. **Public Relations**
_____*Notify area doctors
_____*Newspaper article (release) and doctor's photo
_____*Newspaper advertising (announcement)
_____*Notify area pharmacies

27. **Drug Dispensing**
_____*Label instructions
+ Preprinted
+ Standard
_____*Containers
+ Plastic vial
+ Envelopes
+ Boxes
+ Bottles

28. **Legal Instruments (Documents)**
_____*Lease
_____*Employee contract
_____*Partnership
_____*Janitorial contract

29. **Narcotics**
_____*Safe
_____*License (Has application been made . . .)

30. **Hospitals**
_____*Courtesy or staff privileges

31. **Medical Society**
_____*Notify

32. **X-ray**
_____*Color coding
_____*Files
_____*Folders
_____*Numbering system
_____*Developing solution
_____*Film
_____*Dryer
_____*Automatic developer

33. **Insurance Coverage**
_____*Malpractice
_____*Premise liability
_____*Auto liability
_____*Equipment liability
_____*Office overhead
_____*Disability

34. **Medical Equipment and Supplies**
_____*Determine supplies
_____*Allow 2-to-4-weeks delivery (minimum)
_____*Check on used equipment

35. **Office Furniture**
_____*Open for bids (color, style, fabric)
_____*Coat rack
_____*Magazine rack
_____*Chairs, desks, etc.
_____*Draperies (allow 3-to-6-weeks delivery)
_____*Spiral fixtures

36. **Medical Office**
_____*Blueprint
_____*Colors of room
_____*Type of ceiling
_____*Determine work necessary to occupy
_____*Floors (tile versus carpeting)

37. **Detailmen and Salesmen**
_____*Determine companies to be seen
_____*General policy

38. **Collection Agency**
_____*Reliability
_____*Rates
_____*Policy
_____*Reporting ability

39. **Delinquent Follow-up Procedure(s)**

40. **Special Instructions**

41. **Doctor/Personal**
_____*Coat
+ Color
+ Type, length
+ Personally owned
+ Laundry service
_____*Personal dress
_____*Personal appearance (general)
_____*Nursing caps

42. **Drug Samples**
_____*Method of handling
_____*Dispensation of surplus

43. **Postal**
_____*Postage stamps
_____*Combination for air mail
_____*First-class stamp

44. **Pediatric Pacifiers**
_____*Candy suckers (sugar or sugarless variety)
_____*Toy (inexpensive)
_____*Badges

45. **Patient Traffic**
_____*Chart holders
+ Wall
+ Magnetic (exam rooms, hallways, and business office)
_____*Colored signal flags

46. **Office Hours**
_____*Office procedure
+ Basic data

Time is the test of all things.

1954
1978



BRIEF SUMMARY

Indications: Oral potassium therapy for the prevention and treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. May be used in the treatment of cardiac arrhythmias due to digitalis intoxication.

Contraindications: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause.

Precautions: Potassium intoxication by oral administration rarely occurs in patients with normal kidney function, however, potassium supplements must be administered with caution, since the amount of the deficiency or daily dosage is not accurately known. Frequent checks of the clinical status of the patient, and periodic ECG and/or serum potassium levels should be made. High serum concentrations of potassium ion may cause death through cardiac depression, arrhythmias or arrest. This drug should be used with caution in the presence of cardiac disease.

In hypokalemic states, especially in patients on a low-salt diet, hypochloremic alkalosis is a possibility that may require chloride as well as potassium supplementation.

Adverse Reactions: Nausea, vomiting, diarrhea, and abdominal discomfort have been reported. The most severe adverse effect is hyperkalemia.

Overdosage: Potassium intoxication may result from overdosage of potassium or from therapeutic dosage in conditions stated under "Contraindications". Hyperkalemia, when detected, must be treated immediately because lethal levels can be reached in a few hours.

Kaon® Elixir
(potassium gluconate)
20 mEq per 15 ml

WARREN-TEED
LABORATORIES, INC.
DIVISION OF **ADRIA LABORATORIES INC.**
COLUMBUS, OHIO 43215

Major Medical and In-Hospital Insurance for the Physician and the Family

William A. Head

MAJOR MEDICAL is the broadest form of health care insurance, extending beyond the basic costs of a hospital room and ancillary hospital services. Major medical insurance is the only means of providing much broader coverage for you and your family for payment of those expenses incurred both in and out of the hospital. (For example, the new, revised OSMA Major Medical Insurance Plan provides coverage at home, in sanitariums, nursing homes, or convalescent homes, as well as in the hospital.) This type of insurance also contemplates the necessity and covers the cost of private nursing care both in the hospital and at home.

In designing the OSMA Major Medical Insurance Plan, we took into consideration the special situation of the physician who may or may not extend and/or receive professional courtesy. This is especially apropos in group practices. For this reason, we made coverage for professional services optional to the physician. The OSMA member who chooses the Blue Cross/Blue Shield plan can thus obtain his necessary major medical coverage without being forced to carry additional or overlapping coverage for professional services.

The measure of quality in a major medical plan can best be described in one word, **flexibility.** It must be designed to supplement basic hospital programs such as the "Blues," without creating overlapping or duplicate coverage situations. Major medical insurance should be constructed to coordinate with a basic hospital insurance program. By adhering to this fundamental principal, the premiums are greatly reduced as evidenced by the very low cost of the new, revised OSMA Major Medical Insurance Plan.

The OSMA plan demonstrates another aspect of flexibility in that there are two maximum limits— $100,000 and $250,000. The $100,000 limit is provided in the lower deductibles. The $250,000 limit is provided in the $2,500 and $5,000 deductibles. Obviously, the $250,000 limit eliminates the necessity for a separate excess major medical plan. Still another point of flexibility in the OSMA Major Medical Insurance Plan is a choice of five deductibles ranging from $300 to $5,000, permitting the physician to obtain the catastrophic coverage he/she needs. The higher the deductible, the lower the premium.

As an example of premium cost, consider the case of a 55-year-old OSMA member who wishes to protect himself and his family with the $250,000 major medical plan ($2,500 deductible). Without professional services, the annual premium would be $205.60. Should he elect the $5,000 deductible, the premium would be still lower.

Let us translate major medical benefits into a real-life situation. A physician's wife developed cancer. She went through the usual periods of hospital confinement, where surgery was performed and then radiation treatments were given on both an in- and out-patient basis. It soon became apparent to the physician that with his major medical insurance he could "bring the hospital room home" and continue to provide quality medical care for his wife. Major Medical covered the cost of the hospital bed and other necessary equipment to convert a bedroom into a hospital room. It also covered round-the-clock nursing care and, of course, the cost of the drugs. Since he was a physician, he could monitor the entire situation and his wife could be at home in a more normal, comfortable atmosphere. Obviously, the children felt much better with their mother home again; and all this was accomplished without tremendous financial loss to the

Mr. Head, Portsmouth, is Chairman of the Board of Daniels Head & Associates, a firm specializing in the management of group insurance plans for professional associations.

physician. Had this physician not carried Major Medical insurance, he either would have had to keep his wife in the hospital or bring her home and personally assume the huge costs associated with prolonged periods of illness.

In-Hospital Indemnity

The In-Hospital Indemnity Insurance Plan is probably the most misunderstood and underrated policy being offered to professional people today. They simply do not understand how it fits into the total picture, especially when they are carrying the "Blues" and major medical insurance. A very effective way to put it is: "Recognize that there are other costs besides health-care costs— especially when your spouse or child is in the hospital."

For example, a physician's wife is in the hospital. There are young children at home, and the cost of housekeepers must be considered. As a matter of fact, the cost of maintaining the home goes up when any member of the family is in the hospital. In-Hospital Indemnity insurance is designed to give the insured a tax-free "raise in pay" when he/she or a member of his/her family is hospitalized.

To illustrate, if your wife is in the hospital and you carry OSMA Major Medical along with the "Blues," the medical costs associated with this confinement will be covered under these plans. In addition, with the OSMA Hospital Confinement Insurance Plan, for each day your wife is in the hospital, you would receive a tax-free cash indemnity of up to $150 to defray the additional expenses of the home.

Summary

With the exception of malpractice insurance for physicians, it is generally agreed that, a quality Major Medical insurance plan is probably the most difficult coverage for a company to offer and to manage on a stable and permanent basis. It is extremely difficult to guarantee a $\$1/4$ million protection to each member of a family in excess of a stated deductible without building in what are called "interior limits" on specific services, especially when the cost of such services seems to be forever escalating.

However, the members of the Ohio State Medical Association are aware of the escalating costs of quality health care; and our entire society seems to be addressing itself to the solution of this problem. It is my personal opinion that if Major Medical insurance plans were designed and offered by the insurance industry along the lines set forth in this article, the resultant low premiums would be affordable for most people. I believe that this would obviate the need for any further contemplation of a national health insurance program. I believe such a course by the insurance industry, coupled with the implementation of cost constraint programs by all facets of the health care system, is the only practical answer to continued quality health care in our country.

Harding Hospital

ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

MEMBER BLUE CROSS OF CENTRAL OHIO

ADMISSION AND PRACTICES CONDUCTED WITHOUT REGARD TO RACE, CREED, OR NATIONAL ORIGIN

Offering a Full Range of Psychiatric Services

★ Inpatient Services for 120
★ Individual and Group Psychotherapy
★ Professional Adjunctive Therapy
★ Family Therapy
★ Special Care for the Disturbed Patient
★ Day Treatment for Adults and Adolescents
★ Halfway House
★ Family Care
★ Outpatient Treatment
★ Consultation and Evaluation
★ Special Program for Adolescents, Including School

For further information, call (614) 885-5381

George T. Harding, Jr., M.D.
Medical Director

Donald L Hanson
Administrator

445 East Granville Road
Worthington, Ohio 43085



"...Sleep that knits up the ravell'd sleave of care..."

—WILLIAM SHAKESPEARE, *MACBETH, ACT II, SC. 2*

Insomnia
a shade of blue that often accompanies depression

And, in anxiety/depression, Adapin® (doxepin HCl) often helps restore disturbed sleep patterns, such as early morning awakening, with a single daily dose at bedtime![1] Adapin quickly relieves the patient's anxiety, gradually brightens his mood and outlook, with optimal antidepressant response usually evident within two to three weeks.

1. Goldberg HL, Finnerty RJ, Cole JO: Doxepin: Is a single daily dose enough? *Am J Psychiatry* 131:1027-1029, 1974.

Brief Summary of Prescribing Information
ADAPIN® (doxepin HCl) Capsules

Indications—Relief of symptoms of anxiety and depression.

Contraindications—Glaucoma, tendency toward urinary retention, or hypersensitivity to doxepin.

Warnings—Adapin has not been evaluated for safety in pregnancy. No evidence of harm to the animal fetus has been shown in reproductive studies. There are no data concerning secretion in human milk, nor on effect in nursing infants.

Usage in children under 12 years of age is not recommended. MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with this drug, as serious side-effects and death have been reported with the concomitant use of certain drugs and MAO inhibitors.

In patients who may use alcohol excessively potentiation may increase the danger inherent in any suicide attempt or overdosage.

Precautions—Drowsiness may occur and patients should be cautioned against driving a motor vehicle or operating hazardous machinery. Since suicide is an inherent risk in depressed patients they should be closely supervised while receiving treatment. Although Adapin has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Adverse Reactions—Dry mouth, blurred vision and constipation have been reported. Drowsiness has also been observed.

Adverse effects occurring infrequently include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as sweating, tachycardia and hypotension. Weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash and pruritus may also occur.

Dosage and Administration—In mild to moderate anxiety and/or depression: 25 mg t.i.d. Increase or decrease the dosage according to individual response. Daily dosage, up to 150 mg may be taken at bedtime without loss of effectiveness. Usual optimum daily dosage is 75 mg to 150 mg per day not to exceed 300 mg per day.

Antianxiety effect usually precedes the antidepressant effect by two or three weeks.

How Supplied—Each capsule contains doxepin, as the hydrochloride: 10 mg, 25 mg, 50 mg and 100 mg capsules in bottles of 100 and 1000.

For complete prescribing information please see package insert or PDR.



When they see life in shades of blue... help them see life in all its colors.

Adapin®
(doxepin HCl)

single daily dose recommended h.s.



10 mg capsules
25 mg capsules
50 mg capsules
NEW 100 mg capsules

PENNWALT

Pennwalt Prescription Products
Pharmaceutical Division
Pennwalt Corporation
Rochester, New York 14603

The Best Investment Decision You Will Ever Make

Duane M. Johnson, Ph.D.

WHAT IS THE BEST investment a physician can make? Is it stocks, gold, real estate, diamonds, or one of the myriad of other possibilities that investment advisors or salesmen push? No. For a doctor, this is secondary investing. However, many physicians have become so engrossed in these investments that the primary arena has been slighted, neglected, or completely forgotten.

The primary investment arena involves the physician and his/her staff. The people who assist you in the practice of medicine offer the most security, while also giving you the greatest possibility of personal return, both tangible and intangible.

Importance of the Physician

Since the most valuable asset in a medical practice is you, the physician, it follows that investing wisely in yourself will bring the best return on your resources. Your investment will produce returns that are both monetary and, most importantly, personally satisfying and meaningful.

How does one really invest in himself?

First, define and establish your personal and practice goals. Although these appear to be two different areas, they are actually one because you are one person. Think for a moment about the truly successful surgeon or primary-care practitioner from your community— the one who is highly respected, much sought after, whose words are "pure gold," and who always seems to have more time to enjoy life than you would expect. He speaks with deliberation, indicating leisure; and, yet, you know he is one of the busiest physicians in town. You know he has hundreds of patients, a staff that constantly needs his ear, a wife who desires him home for dinner, two children who want him at the PTA, church committees looking for his attendance, and hospital staff meetings.

How does he do it? His priorities are in order!

What are your priorities? Have you thought about them? Have you written down your personal and practice goals? These goals need to be specific and detailed, perhaps with numbers and dates attached. They cannot be generalized and platitudinous. "Some day I'm going to. . . ." will not suffice.

Seneca, the Roman philosopher, said of goals: "If a man does not know to what port he is steering, no wind is favorable to him." As an effective investor in yourself, you must take the time to clearly establish personal and practice goals; then you must update them periodically.

In order to invest in yourself, you must also develop action plans that assist in enhancing your skills and in managing your time toward the attainment of your personal and practice goals. You cannot **do** a goal. You can only **work toward** a goal through a series of steps. Take time to write down any activity, tasks, or steps you need to take to advance toward that goal. Think about the goal.

By your definition, you are establishing a direction to your life. Using the goal/task lists, plan the basic time units of your day. Do not get caught in the "activity trap." Stick to your planned day. You cannot be all things to all people.

Importance of Personnel

Intimately related to the first primary investment is the second: your personnel. These are the people you choose to represent you and to assist you in your practice of medicine.

"How many staff members do I need?" is a common question. Although the answer depends on a number of factors, always determine to have an adequate number and the best people you can hire for your positions. Surround yourself with excellence, not mediocrity. The people assisting you represent you. The more capable they are, the lighter your workload and, typically, the more financially sound the practice will be.

If you, as the physician, define your personal and practice goals clearly, an organization structure can be determined which defines the amount and types of positions needed for the practice to accomplish your goals. Of course, you are encouraged to use your time for "physician" tasks and to assign all "nonphysician" tasks to your personnel.

Dr. Johnson is Executive Vice President of Practice Productivity, Inc., a management consulting firm based in Atlanta, Georgia.

Once jobs have been defined, you can begin to recruit personnel. The prevailing salary range in the community can be used to determine the salary of each position. Then a recruitment effort must take place to create the largest possible pool of qualified candidates for each job. Use every available source to let people know you are looking. Since the people you will hire will be your representatives, it is worth both time and money to attract good people. After the list of candidates has been collected, begin the selection procedure. Use resume screening, telephone and personal interviewing, reference checks, and all other necessary criteria. Do not leave any stone unturned— this is an important investment which can pay big dividends.

Training Office Personnel

One of the most overlooked aspects of a medical practice is training personnel. Even if experienced, a new employee must be trained in your methods. However, do not forget to listen, for the new person may bring some important experience factors of benefit to everyone.

Effective training requires a plan. Put in writing what you want an employee to know. Often, this can be taken easily from the job description. Take the necessary time to train the employee using the well-respected approach: see it, do it, teach it, record it. Use an adult method of instruction if you expect mature performance. However, adult does not mean complex so make your lessons easy to understand and, therefore, easy to retain.

Salary Increases

"When should I give a raise?"

The answer to this multifaceted question involves the words: evaluation, direction, and communication. The people you employ must receive regular reinforcement to do a good job. Providing such reinforcement will enhance your investment in your personnel. One excellent vehicle for such reinforcement is a private employee-performance review at least once a year.

An employee's performance should be rated against his/her job description task list, with explanations as to where improvement can be made. This will reinforce higher work standards. The review also provides an excellent time to express a formal "thank you" to show personal appreciation. Remember, praise is the "grease of life." Consistently express genuine appreciation, or many unnecessary "squeaks" will begin to be heard eroding an otherwise peaceful practice atmosphere.

At the time of the performance review, it will be obvious where the employee stands in relation to a salary increase. However, a salary review should be scheduled 60 to 90 days after the performance review. This allows motivational time for correction to take place. At the salary review, money should be discussed candidly in comparison to the performance of the employee. Although raises are given primarily for performance, inflation and community standards must be melted into the overall salary determination.

Evaluation of your personnel through individual-performance and salary reviews is a must for providing the employee proper direction and personal identity within the organization of your medical practice.

Employee Dismissal

If a person does not maintain standards of performance as stated in the specific job description for which he/she was hired, definite action needs to be taken. You should hold a performance review with the employee during which you state the behaviors and facts which must be corrected and offer suggestions as to how to do so. In addition, such information should be placed in the employee's personnel file.

There are two rules governing the termination preparation and interview: (1) maintain the dignity of the individual and (2) document all information in the employee's record. If the proper homework has been done in the previous performance reviews, then at the termination interview, it is obvious to both parties that the separation can take place with dignity, fairness, and an adequate amount of respect.

Physician-Employee Communication

The greatest problem that can arise in the employer-employee relationship is lack of consistent communication with personnel. Although "good morning" is necessary, it is not sufficient. In order to function effectively as a physician, you need a solid relationship with your staff. The age-old rule applies: "If you have no communication, you have no relationship."

Some of your time should be invested in a regular meeting with your staff. This should be a once-a-month, structured meeting lasting one hour or less. Several days before the meeting, issue a proposed agenda that allows everyone an opportunity for input. During the meeting, the agenda should be covered expeditiously. Make staff assignments with time limits attached for accomplishing the actions decided upon at the meeting. As the meetings become productive, "success will breed success."

When this meeting suggestion is first mentioned among a group of physicians, the immediate response is: "But, I don't have time." I respond by saying: "You cannot afford not to take the time." This is a priority. If you do not have proper communication, you have no relationship. Maximize the effectiveness of your staff on your behalf; without a solid relationship between a physician and his/her staff, he/she will be limping instead of running, fatigued instead of rested.

Summary

Whatever you do is your choice. But never forget that the greatest investment you can make is developing yourself and those people who work with and respect you.

Aristotle said: "The way to achieve success is first to have a definite, clear, practical ideal— a goal, an objective. Second, (to) have the necessary means to achieve your ends— wisdom, money, materials, and methods. Third, (to) adjust all your means to that end."

ANCEF® IV IM

brand of sterile

CEFAZOLIN SODIUM

(LYOPHILIZED)

For serious respiratory infections

due to susceptible indicated organisms



Bactericidal *in vitro* against susceptible strains*

IV/IM Dosage Flexibility

'Ancef' may be given either IM or IV at the same dosage schedule.

Most infections can be treated with 500 mg. to 1 gram every 8 hours.

(See complete prescribing information in *PDR* or SK&F literature for full dosage instructions.)

Well Tolerated

Infrequent phlebitis; no nephrotoxicity reported. Transient rises in BUN, SGOT, SGPT and alkaline phosphatase have been reported without clinical evidence of renal or hepatic impairment.

Before prescribing, see complete prescribing informotion in SK&F literoture or *PDR*. The following is o brief summory.

Indications: Ancef® (sterile cefazolin sodium, SK&F) is indicated in the treatment of the following serious infections due to susceptible organisms.

***Respirotory troct infections** due to *Streptococcus (Diplococcus) pneumoniae, Klebsiella* species, *Hemophilus influenzae, Staphylococcus aureus* (penicillin-sensitive and penicillin-resistant), and group A beta-hemolytic streptococci.

Injectable benzathine penicillin is considered to be the drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever.

'Ancef' is effective in the eradication of streptococci from the nasopharynx; however, data establishing the efficacy of 'Ancef' in the subsequent prevention of rheumatic fever are not available at present.

Genitourinory troct infections due to *Escherichia coli, Proteus mirabilis, Klebsiella* species, and some stroins of enterobacter and enterococci.

Skin ond soft-tissue infections due to *S. aureus* (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci and other strains of streptococci.

Bone ond joint infections due to *S. aureus*.

Septicemio due to *Str. pneumoniae, S. aureus* (penicillin-sensitive and penicillin-resistant), *P. mirabilis, E. coli,* and *Klebsiella* species.

Endocorditis due to *S. aureus* (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci.

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to 'Ancef'.

Controindicotions: 'Ancef' is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Wornings: BEFORE CEFAZOLIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS.

SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Antibiotics, including 'Ancef', should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Usage in Pregnancy—Safety of this product for use during pregnancy has not been established.

Usage in Infants—Safety for use in prematures and infants under one month of age has not been established.

Precoutions: Prolonged use of 'Ancef' may result in the overgrowth of non-susceptible organisms. Careful clinical observation of the patient is essential.

When 'Ancef' is administered to adults or children with low urinary output because of impaired renal function, lower daily dosage is required (see dosage instructions in the package literature).

A false-positive reaction for glucose in the urine may occur with Clinitest® tablets; use glucose enzyme-type reagents.

Adverse Reoctions: The following reactions have been reported. Drug fever, skin rash, vulvar pruritus, eosinophilia, neutropenia, leukopenia, thrombocythemia, and positive direct and indirect Coombs tests have occurred. Transient rise in SGOT, SGPT, BUN, and alkaline phosphatase levels has been observed without clinical evidence of renal or hepatic impairment. Nausea, anorexia, vomiting, diarrhea, and oral candidiasis (oral thrush) have been reported. Pain at the site of injection after intramuscular administration has occurred, some with induration. Phlebitis at the site of injection has been noted. Other reactions have included genital and anal pruritus, genital moniliasis, and vaginitis.

Administrotion ond Dosage: 'Ancef' may be administered intramuscularly or intravenously after reconstitution. See the package literature for reconstitution procedures.

See the package literature for dosoge recommendations.

How Supplied: 'Ancef' (sterile cefazolin sodium, SK&F)—supplied in vials equivalent to 250 mg., 500 mg. or 1 gram of cefazolin; in "Piggybock" Vials for intravenous admixture equivalent to 500 mg. or 1 gram of cefazolin; and in Pharmacy Bulk Vials equivalent to 5 grams or 10 grams of cefazolin.

ANCEF® IV IM

brand of sterile

CEFAZOLIN SODIUM

(LYOPHILIZED)

Injection: 250 mg., 500 mg. and 1 gram vials

Smith Kline & French Laboratories
Philadelphia, Pa.

SK&F
a SmithKline company

contains no aspirin

tablets

Darvocet-N® 100 ℞

100 mg. Darvon-N® (propoxyphene napsylate)
650 mg. acetaminophen



Lilly

Additional information available to the profession on request from Eli Lilly and Company Indianapolis, Indiana 46206

700565

Eli Lilly and Company, Inc.
Carolina, Puerto Rico 00630

A Primer on Life Insurance

G. Gregory Marquis, CLU

A basic knowledge of some of the principles of life-insurance planning is essential if an individual is really to appreciate the use of the life insurance policy as a financial-planning tool. Therefore, the intent of this article is to generalize answers to the following questions.

**What is the purpose of owning life insurance?*
**How much life insurance do I need?*
**What kind of life insurance should I purchase?*
**How do I select the best life insurance policy?*

Purpose of Life Insurance

It has been written that the purpose of life insurance is purely economic. Simply, *life insurance* is defined as "the purchase of money for future delivery." While it is true that the basis for owning life insurance is closely associated with the economic value of the human life, it is our belief that the primary purpose of owning life insurance is the peace of mind that its purchase affords the owner.

Physicians are more aware than most others that we humans possess no guarantee to immortality. What happens to our hopes, dreams, and ambitions when we die? Do they have to die with us? Certainly not. Thanks to the miracle of life insurance, our hopes, dreams, and ambitions can be accomplished even though death occurs prematurely. This hedge against future uncertainties is the real purpose of life-insurance ownership.

The unexpected death of a breadwinner can create serious problems, especially in the case of a young husband with several children. Ironically, the greatest need for insurance usually comes when the young family is least able to afford it. When the children are older and the estate has grown from investments, the need for economic protection may be much less. Therefore, two rules of thumb regarding life insurance purchases are suggested: (1) concentrate the insurance protection on the income generator; and (2) review the available types of insurance so that adequate coverage can be afforded at each stage of life.

The following are additional uses for life insurance relative to family protection: clean-up fund (ie, funeral expenses, cemetery lot, medical bills associated with final illness, personal loans, taxes [federal estate, state inheritance, and income], and miscellaneous bills such as probate and administration costs); mortgage redemption; readjustment income; dependency period income; widow's life income; educational funds; and wife's insurance.

Amount of Life Insurance Needed

While it is easy to determine the amount of life insurance that an individual might need relative to a specific need (ie, mortgage redemption), the task becomes much more difficult if an individual wants to guarantee that his family will be able to maintain the standard of living that they would have experienced had he lived. How does one determine this need? How much life insurance should an average 35-year-old married individual with two children have? According to the April 1978 issue of *Insurance Marketing,* a national survey by the American Council of Life Insurance showed that 34% of the 1977 respondents believed that the average family breadwinner should have at least $50,000 of life insurance. Family economists generally recommend that life insurance equal four or five times the disposable annual income of a family.

Solomon Huebner, founder of the American College (Pennsylvania) and one of the principle architects behind the Charter Life Underwriter (CLU) movement, has developed a formula to assist individuals in determining their human-life value. Life insurance specialists feel that this is a much more refined method for determining the amount of life insurance that an individual might need. Here is a synopsis of that formula.

First, estimate your average annual earnings for the period between your present age and your age of retire-

Mr. Marquis, Columbus, is Director, Life Insurance Marketing, Turner and Shepard, Inc., a general insurance agency specializing in insurance programs for professional persons throughout Ohio.

ment. Second, subtract income and social security taxes and self-maintenance costs from the annual income determined in the first step. Step three, select an interest rate that you feel accurately reflects the interest that your funds could earn during an extended period of time. (See the Table.) Finally, multiply the annual income from step one minus step two by the present value of $1 per year for the period figured in step one, discounted at the rate of interest selected in step three.

For example, assume that an individual age 45 years has determined that it would take $24,000 per year for his family to maintain their current standard of living. Furthermore, our individual believes that 5% is an accurate estimate of the interest that his funds would earn during an extended period of time. Apply these facts to the Huebner Formula in an effort to determine the individual's human-life value.

Since 12.4622 is the factor used to express the present value of $1 at 5% interest for 20 years, our formula would be as follows:

$$\$24{,}000 \times 12.4622 = \$299{,}092$$

In other words, we can conclude that a lump sum of $299,092 invested at 5% would yield a return of $24,000 per year for 20 years.

Thus, we can see that if an individual takes care in applying the Huebner Formula to his own set of circumstances, it can serve as an accurate guideline in the establishment of a person's human-life value. Furthermore, if that individual sincerely wants to guarantee that his/her family will be able to maintain their current standard of living in the event of his/her premature death, he/she should be willing to purchase an amount of life insurance equal to his/her human-life-value deficit.

Validity of the Human-Life-Value Concept

One method to test the formula is to examine what the courts have allowed families in the event of the wrongful death of the breadwinner. Review of several court decisions indicates that juries had the task of valuing human lives for the purpose of awarding damages to plaintiffs. These monetary awards closely approximated the value calculated by using Huebner's formula.

Type of Life Insurance That Can Be Purchased

Basically, there are two types of life insurance contracts: term life insurance and permanent life insurance. A "term" contract offers financial protection in the event of the insured's death during a stated period of time. If the insured lives beyond this specific period, his term-insurance policy expires and provides no further protection. Thus, term insurance does not cover a certain loss; it only covers a possible loss. Of course, the principle appeal of term insurance is its low cost. It offers maximum protection per dollar of cost during a specific period.

In contrast to term insurance, "whole life" is designed to pay the face amount whenever death occurs. It affords the most permanent coverage over the insured's entire lifetime for the least amount of premium. Additional advantages are the whole-life contract is not "renewable" and the premiums never increase. Also, the insured never has to furnish further evidence of insurability in order to remain covered for the rest of his/her life.

Term Life Insurance

There are many types of term insurance policies. Some of the more commonly used policies are:

Level term insurance.— Typically, this contract offers the same amount of coverage throughout a specific period of time. The great majority of these policies are written for periods of 5, 10, 15, and 20 years. A person also can purchase a level term policy to age 60-65 years or for his/her life expectancy. Level term is also available in policies that are renewable every five or ten years at an increased premium based on attained age.

Increasing term insurance.— This policy has a face amount that gradually increases at a stated rate during the period of coverage. Typically, this type of policy is not written as a separate contract, but only as a rider to a whole-life contract. At death, the face amount of the base policy is payable, plus the amount of the term rider. The period of coverage usually runs for 20 years or to age 65 years. Increasing term is most often sold as part of a "package" offering a return of annual premiums or the cash value at the insured's death, in addition to the face amount of the base policy. In this situation, the annual increase in the face amount is made to equal the annual premium or the annual increase in the cash value.

Decreasing term insurance.— This policy has a face amount that gradually reduces each year at a rate stated in the policy. By the end of the contract period, the face amount of the policy has reached zero. There are two types of decreasing term insurance: "straight-line decreasing" and "mortgage redemption." The straight-line decreasing term policy decreases by the same amount each year or each month, depending on the wording in the contract, for the duration of the contract period. Typically, mortgage redemption policies have a reduction in face amount corresponding to an assumed rate of mortgage amortization. The proceeds are designed to be paid immediately at death, rather than as income or mortgage payments.

"Family income" policy.— This policy is designed to provide income during the period when children are dependent. Since the term of the family income policy should cease when the youngest child reaches an age of financial independence, these policies typically are written for periods of 5, 10, 15, or 20 years. They can be composed entirely of decreasing term or they can be part permanent and part decreasing-term insurance. When selecting this type of policy, an individual has to be aware of the family's dependency period and the insured's ability to pay for the necessary amount of coverage.

Uses for Term Insurance

Term insurance is designed for situations where an individual needs maximum protection at the lowest

PRESENT VALUE OF $1 PER YEAR

The following table shows the present value of payments of $1 at the end of each year for a given number of years, discounted at compound interest.

	Interest Rate									
Years	2½%	3%	3½%	4%	4½%	5%	6%	7%	8%	10%
1	$ .9756	$ .9709	$ .9662	$ .9615	$ .9569	$ .9524	$ .9434	$ .9346	$ .9259	$ .9091
2	1.9274	1.9135	1.8997	1.8861	1.8727	1.8594	1.8334	1.8080	1.7833	1.7355
3	2.8560	2.8286	2.8016	2.7751	2.7490	2.7232	2.6730	2.6243	2.5771	2.4869
4	3.7620	3.7171	3.6731	3.6299	3.5875	3.5460	3.4651	3.3872	3.3121	3.1699
5	4.6458	4.5797	4.5151	4.4518	4.3900	4.3295	4.2124	4.1002	3.9927	3.7908
6	5.5081	5.4172	5.3286	5.2421	5.1579	5.0757	4.9173	4.7665	4.6229	4.3553
7	6.3494	6.2303	6.1145	6.0021	5.8927	5.7864	5.5824	5.3893	5.2064	4.8684
8	7.1701	7.0197	6.8740	6.7327	6.5959	6.4632	6.2098	5.9713	5.7466	5.3349
9	7.9709	7.7861	7.6077	7.4353	7.2688	7.1078	6.8017	6.5152	6.2469	5.7590
10	8.7521	8.5302	8.3166	8.1109	7.9127	7.7217	7.3601	7.0236	6.7101	6.1446
11	9.5142	9.2526	9.0016	8.7605	8.5289	8.3064	7.8869	7.4987	7.1390	6.4951
12	10.2578	9.9540	9.6633	9.3851	9.1186	8.8633	8.3838	7.9427	7.5361	6.8137
13	10.9832	10.6350	10.3027	9.9856	9.6829	9.3936	8.8527	8.3577	7.9038	7.1034
14	11.6909	11.2961	10.9205	10.5631	10.2228	9.8986	9.2950	8.7455	8.2442	7.3667
15	12.3814	11.9379	11.5174	11.1184	10.7395	10.3797	9.7122	9.1079	8.5595	7.6061
16	13.0550	12.5611	12.0941	11.6523	11.2340	10.8378	10.1059	9.4467	8.8514	7.8237
17	13.7122	13.1661	12.6513	12.1657	11.7072	11.2741	10.4773	9.7632	9.1216	8.0216
18	14.3534	13.7535	13.1897	12.6593	12.1600	11.6896	10.8276	10.0591	9.3719	8.2014
19	14.9789	14.3238	13.7098	13.1339	12.5933	12.0853	11.1581	10.3356	9.6036	8.3649
20	15.5892	14.8775	14.2124	13.5903	13.0079	12.4622	11.4699	10.5940	9.8161	8.5136
21	16.1845	15.4150	14.6980	14.0292	13.4047	12.8212	11.7641	10.8355	10.0168	8.6487
22	16.7654	15.9369	15.1671	14.4511	13.7844	13.1630	12.0416	11.0612	10.2007	8.7715
23	17.3321	16.4436	15.6204	14.8568	14.1478	13.4886	12.3034	11.2722	10.3711	8.8832
24	17.8850	16.9355	16.0584	15.2470	14.4955	13.7986	12.5504	11.4693	10.5288	8.9847
25	18.4244	17.4131	16.4815	15.6221	14.8282	14.0939	12.7834	11.6536	10.6748	9.0770
26	18.9506	17.8768	16.8904	15.9828	15.1466	14.3752	13.0032	11.8258	10.8100	9.1609
27	19.4640	18.3270	17.2854	16.3296	15.4513	14.6430	13.2105	11.9867	10.9352	9.2372
28	19.9649	18.7641	17.6670	16.6631	15.7429	14.8981	13.4062	12.1371	11.0511	9.3066
29	20.4535	19.1885	18.0358	16.9837	16.0219	15.1411	13.5907	12.2777	11.1584	9.3696
30	20.9303	19.6004	18.3920	17.2920	16.2889	15.3725	13.7648	12.4090	11.2578	9.4269
31	21.3954	20.0004	18.7363	17.5885	16.5444	15.5928	13.9291	12.5318	11.3498	9.4790
32	21.8492	20.3888	19.0689	17.8736	16.7889	15.8027	14.0840	12.6466	11.4350	9.5264
33	22.2919	20.7658	19.3902	18.1476	17.0229	16.0025	14.2302	12.7538	11.5139	9.5694
34	22.7238	21.1318	19.7007	18.4112	17.2468	16.1929	14.3681	12.8540	11.5869	9.6086
35	23.1452	21.4872	20.0007	18.6646	17.4610	16.3742	14.4982	12.9477	11.6546	9.6442
36	23.5563	21.8323	20.2905	18.9083	17.6660	16.5469	14.6210	13.0352	11.7172	9.6765
37	23.9573	22.1672	20.5705	19.1426	17.8622	16.7113	14.7368	13.1170	11.7752	9.7059
38	24.3486	22.4925	20.8411	19.3679	18.0500	16.8679	14.8460	13.1935	11.8289	9.7327
39	24.7303	22.8082	21.1025	19.5845	18.2297	17.0170	14.9491	13.2649	11.8785	9.7570
40	25.1026	23.1148	21.3551	19.7928	18.4016	17.1591	15.0463	13.3317	11.9246	9.7791

premium outlay, particularly where the need is temporary. Term can be used to cover permanent needs, but it should be used only in situations where the insured understands that it is to be done on a temporary basis or until he/she can afford permanent insurance. In other words, term is useful as an *option to buy* permanent insurance, but is not a long-range substitute for it.

Typical uses for term insurance include the need to (1) provide cash or income during a child's dependency period; (2) cover debts, loans, or mortgages that will be repaid within a limited period of time; or (3) provide protection for dependents of a breadwinner who cannot afford the necessary amount of permanent insurance. Specifically, a term insurance program may be the ideal solution for a young physician who wants to start his insurance estate while insuring his future insurability.

Term Insurance Limitations

The limitations of term insurance become apparent when it is misused for permanent needs. In too many instances, the term-insurance buyer is so influenced by the low premium rate that he does not consider that the rate is low because the coverage is for a limited time only. Typically, term insurance enjoys the advantage of having the lowest *initial* cost; but if carried for an extended period of time, it can have the highest *ultimate* cost.

Term insurance can give the insured a false sense of security. This often happens when an individual neglects to convert his term insurance when he is financially able or delays conversion until an age when premium rates for permanent insurance are so high that he cannot afford as much as he needs.

Whole Life Insurance

From a premium-payment point of view, there are three kinds of whole life contracts: (1) ordinary life, (2) limited-payment life, and (3) modified- or graded-premium life.

Ordinary life.— This insurance contract involves premiums which are payable for life or to age 100 years. This does not mean that the whole life purchaser has to pay premiums for his entire life or even to age 100 years. It simply means that if premiums were paid to age 100 years, the sum of the premiums plus the interest earned on the premium payments would equal the face value of the policy at age 100 years. With this definition in mind, it is obvious that insurance companies can offer variations of the whole life contract by changing the period of time at which the policy premiums plus interest will equal the face value of the contract. For instance, a life paid up at age 85, 90, or 95 years can be considered the equivalent of an ordinary life policy, since the premiums and the cash values prior to age 65 or 70 years are about the same.

Flexibility of the Ordinary Life Contract

Ordinary life is the most flexible type of life insurance on today's market. It easily can be adapted to changes in the insured's financial situation or family responsibilities. The following items illustrate some of the flexibilities of the ordinary life contract.

The ordinary life policy can be placed on the paid-up insurance option. If the insured is unable to continue paying premiums or if his insurance needs are reduced, he can elect to take a paid-up policy for a reduced face amount.

The extended-term option enables the insured to continue the full face of his contract for a temporary period without further premium payments. This option is valuable in situations where the insured can no longer afford to continue paying premiums, or where he has a terminal illness and is not expected to live beyond the contract period.

Cash values increase each year and are available for opportunities or emergencies. Examples might be: a down payment on a home, office equipment, educational funds, or cash for investment opportunities. Cash values may also be converted to produce a lifetime income. Thus, the policy that protects the insured's family may also supplement his own retirement.

Dividend options available on participating policies provide additional flexibility. They can be used in a variety of ways such as to (1) accumulate at interest, (2) reduce future premiums, or (3) purchase additional insurance.

Uses of Whole Life Contract

Whole Life should be the cornerstone of the great majority of life insurance programs because of its great utility and flexibility. Its flexibility gives it many uses (ie, protection and retirement needs). The whole life policy provides substantial protection during the "family dependency" years, while at the same time builds cash and income values that can be used as retirement income supplements. In the interim, the cash values serve as a reserve fund for opportunities and emergencies.

Because of the life-long nature of the whole life contract, the insured does not run the risk of underestimating the duration of a particular need. Rarely does a person ever outlive his need for providing protection against death's financial impact, since his/her death invariably creates sizable expenses.

Limited-Payment Life

Limited-payment life is very similar to whole life except that the premiums are payable for a specified number of years (ie, 10-, 20-, or 30-pay life or life paid up at 65). The longer the premium payment period of the limited-pay policy, the more closely it approximates the whole life contract. Since the premiums of the limited-pay policy are substantially higher than those for an ordinary-life policy, it stands to reason that the former would generate higher nonforfeiture values.

The primary advantages of the limited-pay contract are that the higher premiums produce a fully paid-up policy sooner and the purchaser knows in advance the maximum gross outlay needed to purchase his insurance.

Limited-payment life policies are especially well suited for situations when the insured wants to pay premiums during his most productive years and can afford the needed amount of insurance despite the higher premiums. Another popular use for this type of contract is where a parent or grandparent wants to start a child's insurance program that will be paid up at a relatively early age.

Modified- or Graded-Premium Life Contracts

Modified- and/or graded-premium plans are essentially ordinary life contracts having initial premiums that are lower than premiums for regular whole life but higher than term premiums. The final premium rate is always more than the ordinary life rate for the age at issue, but less than the ordinary life rate for the age when the final increase occurs. The ultimate result is that the insured eventually pays the actuarial equivalent of whole life premiums.

The lower initial premiums on these plans offer those with temporary limited means the opportunity to initially purchase a permanent plan of insurance rather than beginning with term insurance. A typical situation where a modified or graded-premium plan might be suitable is one in which an intern or a resident with a family wants to start his permanent insurance program at the lowest possible initial premium. Since he has a better-than-average prospect of increased future income, he should be more than able to meet the increased premiums without hardship. Since the graded-premium contract is essentially the same as ordinary life, it is suited for the same uses as ordinary life.

Conclusion

No one type of policy is "the best" for all situations. However, there is a policy type that best fits a particular individual's needs and premium-paying ability. In order to determine the right policy for an individual, the prospective buyer should consult with a knowledgeable, trustworthy insurance agent. During their consultation, the agent must determine:

★ What are the prospect's present and future financial obligations to his dependents?

★ What are the prospect's financial ambitions for his family and himself?

★ How much additional family protection is needed and for how long?

★ What importance should be given to protection needs as compared to savings and retirement needs?

★ How much retirement income does the prospect want and from what other sources will this retirement income come?

★ How much of his current income is he willing to devote to additional life insurance?

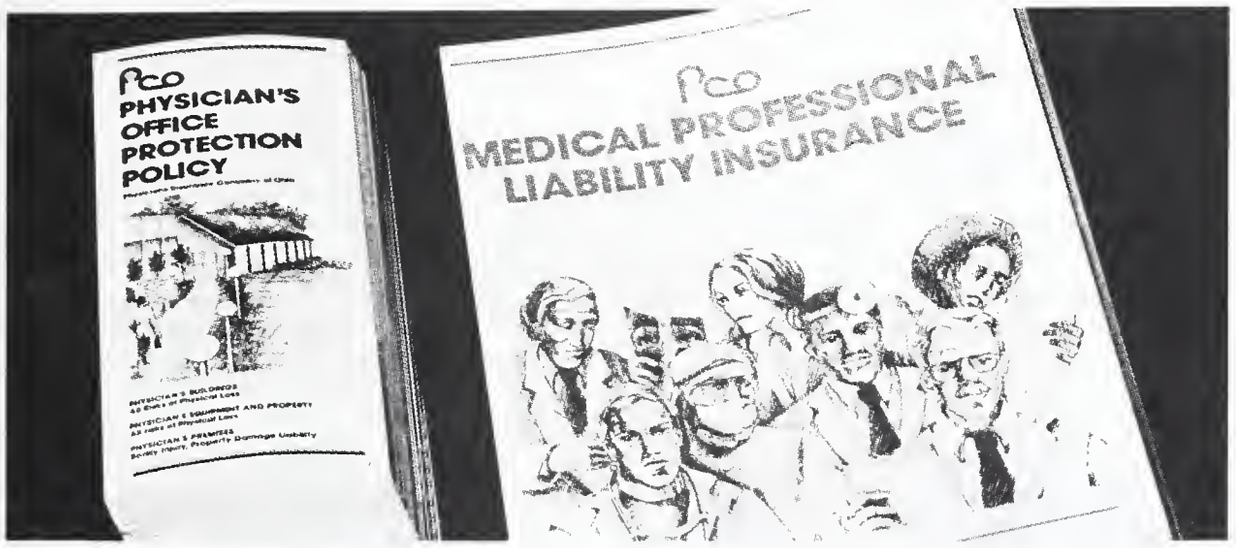
Until these questions are answered, an insurance agent is not in a position to recommend knowledgeably the policy that will best fit the prospect's situation.

In the July Issue:

The Proceedings of the 1978 OSMA Annual Meeting

A UNIQUE INSURANCE COMPANY

TWO POLICIES– COMPLETE PROTECTION



Pico's Office Protection Policy for physicians protects your medical office building, equipment and property against physical loss, and includes medical premises liability coverage.

Pico's medical professional liability plan protects you against claims arising out of the performance of medical services.

Pico gives you complete protection for your medical practice through only two policies.

And, by having both medical professional and medical premises liability with the same insurer, there is no possibility of costly, time-consuming litigation over which coverage may apply to a specific claim.

This is the kind of service you can expect from PICO, a unique insurance organization. After all, PICO is a stock insurance company formed by OSMA physicians and owned by OSMA physicians, to serve OSMA physicians.

Physicians Insurance Company of Ohio
6100 Channingway Boulevard
Columbus, Ohio 43227
For the name of the PICO authorized representative in your area, call toll free 1-800-282-7515



Tolinase®
tolazamide, Upjohn

Please contact your Upjohn representative for additional product information.

Upjohn

J-5695-6

©1977 THE UPJOHN COMPANY

Billings and Collections in the Physician's Office

Robert S. Mauck
Michael M. Wagner

PROFESSIONAL MANAGERS TEND to dedicate a great deal of time to the management of the profits generated in a successful practice. Emphasis is placed on professional incorporation, taxes, and the investment and portfolio management of deferred-compensation plans. To be sure, the capital growth of a practice is essential, but far too little attention is focused upon the medical practice as a revenue producing enterprise.

One of the initial tasks faced by the physician in private practice is the implementation of a system which can bill and collect his fees effectively. Few business decisions made by the doctor will have a more dramatic effect on the profitability of his practice. Regardless of what some say to the contrary, prosperity is neither automatic nor common to all physicians. The generous rewards enjoyed by some physicians are the product of good patient care, hard work, and skillfull accounts-receivable management. The discussion to follow addresses some of the essential ingredients requisite for achieving proper accounts-receivable management and control.

From the patient's first visit to the doctor's office to the final settlement or termination of the account, the pervading element which can become so costly to the physician is time. Every action taken to shorten the time span between the initial billing of a patient and his final payment is very important to the productivity of the practice.

Significant statistical studies have been done to illustrate the consequences of extending the payment of an account over varying periods of time. These studies are not of prime importance here, but it is critical that the physician appreciate the fact that the slow payment of accounts is one of the largest expenses in his practice. Not only does the practice assume the added costs of maintaining delinquent accounts on the books; but the older the account balance becomes, the greater the risk of default.

Mr. Mauck, Columbus, is President of Consolidated Business Services, and Management Consultant with Professional Practice Management, a Division of Consolidated Business Services.

Mr. Wagner is associated with the Central Bookkeeping Division of Consolidated Business Services in Columbus.

Basic Principles of Accounts-Receivable Management

Before a study of billing and collections in the physician's office is developed in detail, it may be valuable to consider three basic principles of accounts-receivable management as they apply to the private practice of medicine.

Credit Terms— Few physicians have dared to establish firm credit terms with their patients. Nevertheless, the actual terms of credit in a practice are evidenced by the relative leniency granted a patient regarding the propitious settlement of his account.

The credit terms of the practice directly impact the turnover of receivables and the frequency and dollar cost of uncollectables. The physician must pay keen attention to the credit terms he exercises, and the ultimate effect these terms have on his total receivables.

Default Risk— The credit terms of the practice, however loosely defined, not only influence the slowness of collections, but also govern the portion of the receivables defaulting. There is a functional relationship between the rate of accounts-receivable turnover and bad debts. The more accommodating the terms of credit, the greater the risk of default.

Collection Policy— The overall collection policy of a medical practice is determined by the various collection procedures employed by the physician's staff or billing agent. The question is simply: How old should an overdue account be allowed to become before more aggressive collection efforts begin? Because a receivable is only as good as the likelihood that it will be paid, a physician cannot afford to wait too long before initiating collection procedures.

These procedures should be firmly established and consistently put into operation. If all else fails, the physician must be prepared to turn over delinquent accounts to collection or cancel the unpaid charges to preserve the veracity of the total accounts receivable of the practice. The collection procedures are vital to effective accounts-receivable management.

Physician-Patient Transaction

The Figure is a sequential outline of the basic elements involved in the doctor/patient encounter from the point of registration to the final settlement or termination of the patient's account. From a billing-and-collection perspective alone, the components of this schematic will be reviewed in some detail.

Financial Counseling.— To properly care for the needs of a new patient, the doctor must obtain some knowledge of the history of the patient's physical and psychological well being. From a billing point of view, the occasion of patient registration may be the optimum time to explain the credit policy of the practice. Many practices have successfully used this opportunity to provide the patient with some basic financial counseling which should be brief and unintimidating. Whether this discussion precedes the physician's examination and treatment or concludes the patient's visit, the following objectives must be accomplished:

(1) The credit policy regarding billing and payment for services rendered should be reviewed.

(2) All billing information must be gathered and recorded.

(3) Third-party details regarding subscriber information (name of carrier, group numbers, certificate numbers) must be recorded. In the State of Ohio, it is absolutely essential that recipients of Medicaid assistance show their eligibility by presenting their "Medical Assistance Identification Card." The reader is reminded that the Ohio Department of Public Welfare reissues this card every month. Check the "void after" date shown on the card.

Insurance, Medicare, and Medicaid details should be recorded or photocopied and retained as a part of the patient's file. The more conscientious the physician's staff is in collecting and recording this information, the more precise and complete the initial billing and the higher the probability of prompt payment.

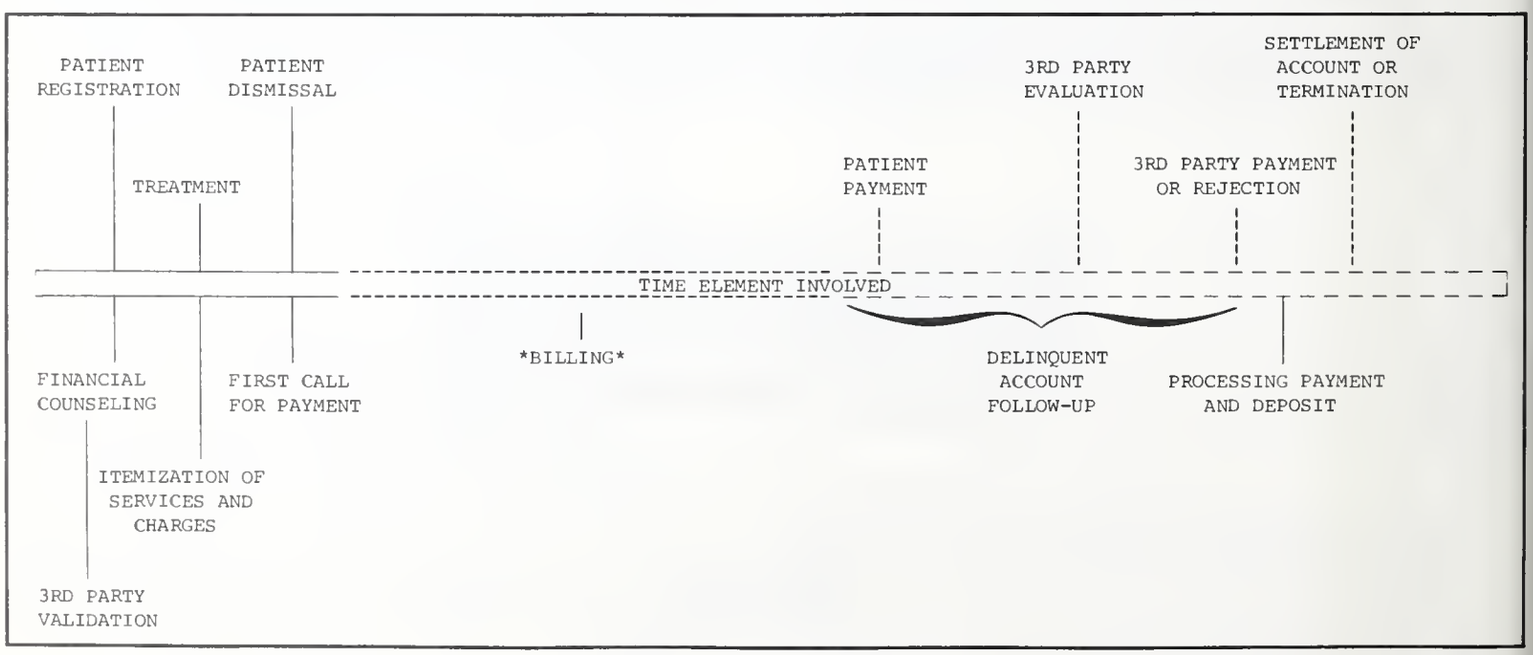
Itemization of Services and Charges.— The explicit itemization of services rendered with respective charges is important to clear physician/patient communications. Needless to say, it is a prerequisite to the settlement of third-party claims. The development of the encounter slip or fee ticket has helped to facilitate the recording of this information. After examining the various products and systems available on the market, the physician should select the document and develop the supporting procedures which serve his practice best.

Patient Dismissal.— As mentioned above, the physician may wish to use this time for his billing secretary or an appointed member of his staff to consult with the patient regarding his/her financial responsibility. However, the emphasis at this point is "Ask for payment!" Some doctors continue to resist the concept of payment at the time of service; and in certain specialties or under unusual circumstances, such an effort could be imprudent. The doctor must decide for himself what procedure is appropriate, but he should keep the following in mind:

(1) A large and growing number of physicians are successfully implementing this procedure.

(2) The patient is becoming more and more disposed to payment at the time of service. In today's world, there are few situations where one can receive a service today, and enjoy credit terms extending payment over 30, 60, or 90 days or longer without an interest charge. Special circumstances or personal preferences notwithstanding, asking for payment at the time of service is not unprofessional. It is becoming an acceptable practice, even in medicine.

Insurance versus Self-Payment.— There appears to be an almost universal misunderstanding of the relationship between the patient, his independent insurance company's coverage of medical care, and the physician. There is no contractual relationship between the private insurance company and the physician. The patient may elect to step



The Physician/Patient Transaction

aside, presuming that the responsibility for payment is now his insurance company's, but he is mistaken. The contract is struck between the patient and his carrier, not the carrier and the doctor. The patient is ultimately responsible for payment regardless of his coverage, and he must expedite settlement by cooperating with the physician.

A word of caution. As a practice succeeds in acquiring more and more payments at the time of service, it becomes very important that certain checks and balances be installed to secure the practice from the risk of defalcation.

The opportunity to embezzle funds from a doctor's office is a compelling temptation to a dishonest employee. While no single procedure can completely protect a practice, several techniques can be used to help secure its financial integrity. The physician should take steps to monitor and test his office procedures and the conscientiousness of his personnel.

Billing

With preliminary financial review and data gathering completed, the actual billing operation begins. Regardless of the system employed, from an elementary ledger-card method to the most sophisticated computerized system, all billing routines must achieve these objectives:

(1) Render a detailed and clear statement of services and charges.

(2) Accommodate the multiple requirements of third-party carriers.

(3) Get a statement into the hands of the patient or third-party promptly.

The accomplishment of these demands is no easy task, and the physician needs to take great care in selecting his staff and the billing system, which will either enhance his cash flow or sabotage the fiscal vitality of the entire practice.

The initial billing of an account may well be the single most important business operation in a medical practice. The rate of turnover of accounts receivable has a critical impact on the productivity of a practice. Therefore, the more efficient the first billing, the higher the probability of prompt payment. The longer the practice must wait for payment, the more costly the billing function becomes. In this instance, time is truly money.

There is an average lag between invoicing and payment in all types of accounts. This means that depending upon the profile of a particular practice (ie, the dollar amount of self-pay, insurance, and Medicare and Medicaid charges as a percent of total receivables), there is a predictable and largely unalterable collection or average turnover period. Whenever problems in data gathering, claim-form preparation, or billing which cause this optimum target collection period to move further and further away from the initial statementing of the account, the risk of default and the cost of billing increase. (Thus, the earlier emphasis on payment at the time of service.)

Since this mean collection interval is a virtually fixed period of time, the initial billing must be prompt, correct, and complete for a practice to achieve the quickest possible turnover of receivables.

It is the relatively unmanageable nature of the target turnover period which can make a professional billing service so valuable to some practices. A computerized medical billing system can be designed to establish direct entry communications with third-party carriers and, thereby, reduce the lag between billing and payment from months to weeks. An automated billing system is the only system which can dramatically shorten this average turnover period.

Collections

In all medical practices, consistent, delinquent-account follow-up should be enforced. The billing system must be able to identify past-due accounts and initiate strict collection procedures. The aggressive pursuit of delinquencies is a key responsibility of the practice. Excessive leniency will disrupt the financial well being of the practice and ultimately weaken the reputation of the physician.

Regardless of the methods employed, dun messages, precollection letters, or personal telephone calls, the fundamental ingredient is discipline. Collection procedures must be executed consistently at specified intervals and must continue for a prescribed period of time, generally not to exceed eight months from date of service. At that point, the doctor should turn the account over to a professional collection agency or be prepared to write off the balance of the account.

Two excellent articles have appeared in *Physician's Management,* the first dated March 1977 and the latest January 1978. These articles summarize the findings of two broad surveys involving more than 9,000 physicians in various specialties. Among other important details, these articles confirm that very successful physicians average between a 93.6% and 98.4% collection ratio, depending upon specialty and location. Considering the impact that some third parties who do not pay full fees have on a practice, these collection ratios are extraordinary. Of course, many variables contribute to this exceptional performance. However, these articles emphasize the importance and dramatic impact skillful accounts-receivable management can have on the financial health of all medical practices.

Summary

We do not presume to have adequately developed all of the billing and collection techniques which could be used to maximize practice productivity. Skillful accounts-receivable management is both and art and a science. Hopefully, this discussion of billings and collections in the physician's office will encourage the reader to examine the financial health of his practice. The able and hard-working physician is entitled to the generous rewards which can be earned in the medical profession, but these rewards are only enjoyed by the doctor who is willing to take a firm hand in the business management of his practice or to seek the help of professional business consultants.

EMERGENCY PHYSICIANS
FULL-TIME AND DEPARTMENT DIRECTORS
INTERESTED IN EXCELLENCE
AND
CAREER ORIENTATION

AmeriCare Emergency Services is a rapidly growing national Emergency Medicine Group which emphasizes professional growth in Emergency Medicine through extensive medical education benefits as well as excellent compensation for physicians qualified to join our group practice full-time.

Opportunities for Emergency Department Directorships and full-time group practice exist with **AmeriCare** in a variety of community settings to fit your preferred lifestyle. Our contracted Emergency Medical Services are located in urban, suburban, and rural acute hospitals across the United States.

If you are selected, you will enjoy lucrative compensation based upon a percentage of your Emergency Department's gross revenues, with a substantial guaranteed minimum income. Our central office staff of health care professionals, highly skilled in Emergency Department systems, finance, and community relations, will enable you to direct your energies to the practice of medicine, without the burden of office overhead and administrative headaches.

Perhaps most importantly, an Emergency Medicine practice with **AmeriCare** offers you freedom of regular hours, so that you can pursue your life's other interest without untimely interruptions.

We offer a broad benefit package encompassing all malpractice insurance costs, fees associated with your preparation for Emergency Medicine Boards, assistance in establishing your own professional medical corporation, liberal vacation and health benefits.

We invite physicians who have had Emergency Department clinical experience to send their curriculum vita and their geographical preference to Geoffrey M. Hosta, M.D., Executive Director, AmeriCare Emergency Services, 606 Wilshire Blvd., Suit 504, Santa Monica, California 90401.

If you are serious about a growth future in providing high quality Emergency Medical Services, contact **AmeriCare** now.

Call Toll Free 800/421-6655

Proper Estate Planning for the Physician From the Standpoint of a Probate Judge

The Honorable Richard B. Metcalf*

UNDER THE 1976 TAX ACT, your heirs may have to pay income tax on the ultimate disposition of all property they receive by reason of your death, in addition to paying a death tax. Under prior law, property rights acquired by reason of death generally received a new income-tax cost basis computed on the value at the date of death or the value accepted for the federal estate-tax return. The 1976 Tax Act made a substantial change, and I assume that your attorney and your accountant or your business manager have made you aware how this act may relate to income-producing properties.

There seldom is any problem in determining the decedent's remaining cost basis in income-producing properties because these are detailed in his/her annual income tax return. However, very few people pay any attention to the income-tax cost basis of their personal residence property. In many instances, unless you have asked your attorney, accountant, or business manager to review this, he might have no idea what your true cost basis might be.

Neither this article nor this *Journal* contains enough space to explain all the intricacies of calculating cost basis after your death. However, there are certain items you must complete now, because if you fail to do so, they probably cannot be discovered by a third person.

First Residence

When you acquired your first residence, the forward progression of your cost basis began. It is necessary to know what you actually paid for this property. You also must have in some intelligent form the price for which you sold, the cost basis of your sale, and any capital improvements made to that property. This same information is needed for each succeeding residence property.

A typical case is the purchase of real estate 30 to 35 years ago, generally with a very small sum of money. Two years after the initial purchase, the owner added a garage — which is capital improvement. Each dollar spent adds to the owner's original income-tax cost basis and, ultimately, may save his/her beneficiaries from paying income tax to the degree that they can prove these expenditures. Four or five years after the original acquisition, the owner probably added an air conditioner. It too is a capital improvement and adds to the original cost basis. Subsequently, the owner sold the property. This was a reportable and taxable sale unless those proceeds were invested in another residence property. In such an event, there was no taxable sale. However, the cost basis from the original property comes forward into the second acquired residence property.

Let us say the first property you purchased was worth $20,000; your sale of it was for $30,000; and you bought a new property at $40,000. With no more complication, the only actual cash put up for the residence property is a total now of $30,000— which is the income-tax cost basis. Increasing this figure are the costs of the garage, the air conditioner, and the storm windows that you added to the residence. You have many questions concerning whether something is or is not a capital improvement (ie, replacement of a hot water tank).

As tax laws change, I would not advise you to pay someone to make decisions on each item. By the time you die, a specific exemption for tax of personal residence may have been created because of the tremendous complication in knowing what the original cost basis of such property is. I do recommend that whether you believe it is a capital improvement or a maintenance item, you make particular note of the cost, who did the job, how it was done, and what was previously there.

For instance, if you had a side-burner, hot water tank of small capacity and you install an automatic, large-capacity tank, it may qualify, at least in part, as a capital investment. The same might be true of a roof if you had a tar paper roof and went to an exotic, expensive, tile roof. Another item many people forget is outside shrubbery and trees. These are also capital investments.

If you could not find the costs of these items two to three years after purchase, you can imagine how difficult this might be for your spouse or children. Each dollar that

*Judge of the Franklin County Probate Court, Columbus, Ohio.

you add to your cost basis might very well be worth 35¢. After being a property owner for 35 years, it is not difficult to lose track of $10,000 to $15,000 of capital investments in your property.

Once you have compiled this information, be sure that your advisor, your wife, or one of your children know where it is in event of your death. A tax advisor will have very little success gathering this material after your death; this task is one of the most important tax-saving items you can accomplish.

Generation-Skipping Trusts

The 1976 Tax Act also changed, to some degree, the death-tax-saving device of generation-skipping trusts. I am sure many of you have a will that has a tax-savings trust accompanying it. I suggest that you visit your advisor to see if it meets all the requirements of the new law. Practically all of these trusts need some adjustment to reach their maximum effectiveness.

Through a series of maneuvers, it is possible to move as much as $\$1/2$ million without estate taxes into the hands of your wife by prior-to-death gifts and death transfers. However, it is not possible for the surviving spouse to pass this money to the next generation without incidence of estate taxes. Under current law, your spouse can pass as much as $120,000 to $175,000— maximum in 1981— without incidence of federal estate tax. Under prior law, a surviving spouse at death could pass to children only $60,000 without estate tax.

If I leave property to my wife, it might be subject to estate tax. If at death she leaves property to my son, it probably will be subject to estate tax. Then he might leave the same property to my grandchildren, which again might be subject to estate tax. As you can see, the same property easily could have been taxed three times. However, if I leave my property to a trust for the benefit of my wife, it will be subject to estate tax at my death but very well might escape all taxation at her death, or at least be subject to substantially limited taxes at her death. It might escape taxation at the death of my son and be passed down to my grandchildren. In other words, my estate could be subjected to only one tax bite instead of three tax bites.

Basically, this is the simplest form of explaining generation-skipping trusts. However, as you might guess, it really is not that simple. A good tax technician is needed for you to receive this effect on your property.

Trusts for Children

Under current Ohio law and the trend in many other states, children will reach full majority at age 18 years. This means that if you write a simple will which leaves everything to your wife, unless she predeceases you and then everything is left equally to your children, your children could have the entire sum of money without restraint when they turn 18 years of age.

Consider a typical case. You and your wife are killed when the children are 15 years old or you are killed shortly after you have divorced your wife and you left your property to your children who were then 15 years old. When they turn 18 years of age, they are free of all restraints. You might think that there is not a great deal of liquidity in your estate. That generally will not be true. All of your life-insurance proceeds are paid in cash. Seldom is your residence property kept by an 18-year-old— it is normally sold. Your office is closed and rendered into cash. Even though you say "I really never carry a cash balance in a bank account of more than $1,000," I believe the minimum sum your child will come into will be $50,000 to $100,000.

Look back and be honest with yourself, at the age of 18 years could you have resisted temptation with that sum of money? I find that very few children can. Some are able to resist when a living parent exerts some control; but in the case in point, you are no longer living. To me, such an inheritance is a very cruel temptation to place before a child if you want him/her to be a success. In most cases, before the child reaches age 25 years, he/she is broke.

To assume the responsibility of managing this kind of wealth, a child decides the first thing to do is rest his/her brain and so usually drops out of school. Therefore, the child gets no education. Inheriting money has allowed the child to avoid one other major factor— work experience. If you leave everything you have to charity, your son or daughter probably will be better off at age 25 years because, in order to eat, he/she will have acquired substantial work experience.

I am sure you think that I am exaggerating in relation to your children, but I find kids from every walk of life who have squandered away substantial sums of money in very short periods of time. Recently, this court saw one who came into some $70,000 when he turned 18 years of age. It lasted him ten days: he was living in a commune with 30 other kids; the first day he purchased 22 motorcycles; the pot party started in Ohio and ended in jail in upstate New York. I am not sure that he knows how he got there, but it must have been a wonderful time that he will long remember. Yet, he was dead broke. Having known that he was coming into this money since he was 15 years old, he immediately had started resting his brain by dropping out of school. Although he was a truly pitiful case, he is not the rare example.

I strongly suggest that you think seriously, not only about tax savings but about money management, in creating a trust to handle the money of a young person at least until he/she is 25 years of age. Most trusts would perpetuate some control through possibly age 35 years, giving the child one-third of the estate at age 25, one-third at age 30, and one-third at age 35 years.

One other comment involves the choice of trustee. You may think your brother-in-law is a good, stable citizen; but I feel you are not doing him a favor if you ask him to be the trustee. He will be "sitting on" $50,000 to $100,000 and trying to convince the youngster that driving a sports car to college is not a good idea. You will have placed your brother-in-law in a very difficult position.

If you do not intend to do anything else in the way of money management for young people, give the money

to charity. At least your children will amount to something when they reach adulthood.

Trusts for a Spouse

Many wives resent a trust imposed over their inheritance. They feel that their husbands think of them as incompetents in money management. In many cases, your wife might be more competent in money management than you; but neither of you has had the problems that she will have at your death.

Everybody knows that there is substantial liquidity at the death of any white-collar worker; and certainly, there almost always is substantial liquidity at the death of a physician. Your insurance death proceeds are paid in one check. The investment in the physical property of your office is substantial, let alone the accounts receivables. These will be reduced to cash. There will be a hoard of people trying to reach the "pot at the end of that golden rainbow."

Consider a situation. If you were to go through bankruptcy tomorrow and lose your license to practice medicine, in all probability, you will have groceries on the table tomorrow night by cutting grass or raking leaves or getting a job as a used car salesman. What about the widow that you leave behind who has not been in the labor market for 30 to 35 years, who has gotten just a little plump, who would have trouble standing on her feet for eight straight hours each day, who probably would be a little slow in waiting table at the corner beanery? She is not a choice item on the labor market.

I do not mean to be a male chauvinist, but I mean to bring home forcefully the true fact in most situations. If your spouse were to lose the financial accumulations that the two of you have been able to make over the years, she probably will never be able to recoup the same economic position that she now holds. As financial security is most important to her, she— like the 18-year-old— very well might benefit from professional money management simply to keep the vultures away from her.

You may laugh and say your spouse would not go for any such "con" game; but once the money goes up in smoke, it is almost impossible to recover. Our court has been involved directly and indirectly in three different cases concerning one man who has taken about $\frac{1}{4}$ million from three women. (The total loss is unknown because most people will never admit that they have been taken by a "con" man.) He is not a person I would think particularly attractive— over 65 years, balding, and quite gray. Apparently, somebody finds his company to be quite enjoyable; for in the span of a year and a half, I have seen these ladies enjoy a $\frac{1}{4}$ million worth of company.

Picture the typical widow with two adult children and possibly grandchildren. Generally speaking, she gets the opportunity of a personal visit for three or four days once a year. She may or may not get a letter once a month. This hardly keeps her from becoming very lonely, and it is no wonder that such a widow is very receptive to meeting a good conversationalist who frequently turns out to be a "con" man. Certainly, this does not imply that every person who wants to befriend a lonely widow is expecting to line his pockets with her money, but it is almost impossible to know which ones are just friendly and which ones have a substantial profit in mind.

Incompetence

Everyone of us will be incompetent for some period of time before we die. If I die while dictating this article, I will have been incompetent for 30 seconds. If I die at age 80 years from hardening of the arteries, I might have been incompetent for 8, 10, or 12 years. At some point in time, I am going to need assistance in financial management. Even if you think a widow currently might be able to manage money, there will come a time when she will not be able to do so. The one answer to this dilemma is creating a money-management trust.

One caveat— do not try to run everything from the grave. Give your trustee plenty of discretion, both as to investment and distribution to the beneficiaries. We still have trusts that read: "I want my wife to live in the lavish manner to which she has become accustomed. I, therefore, give her $75 a month." One such trust now in this court has a cash balance of about $600,000. If your thoughts have been put in clear language, your directives will be followed. Give the trustee the latitude to pay out that sum of money which he determines to be necessary for her comfort and enjoyment of living.

Another common phrase we find in trusts is "my wife shall be a beneficiary of this trust so long as she remains unremarried." This does not say a word about with whom she is sleeping. Why should you care if she remarries? I always considered it a bit like ice cream. If ice cream stung my teeth the first time I ate it, I probably would not eat any more. If my first marriage was a bad one, I probably would not want another. It is no compliment to you if she does not want to remarry.

Conclusion

Please do not read this article and assume that you can now proceed with a do-it-yourself estate plan. In almost every case that I have seen of this nature, the individual would have been much better off doing nothing rather than a do-it-yourself program.

You can cut costs with your lawyer if you go prepared— possible no more than writing the proper spelling of each name of people that you want to benefit in some way. Develop your idea of what your cash assets look like. Your lawyer might not agree with this, inquiring more deeply into certain assets and reminding you of other unlisted assets such as children's bank accounts (accounts in joint name with the parent that might be taxed at the parent's death even though it is thought children own them), or children's life insurance policies of which the parent is the owner.

Remember, lawyers love people who try to create their own legal documents for this begets tremendous legal problems after death accompanied by substantial legal fees. However, the injury arising from improper estate planning will affect the *family* of the deceased.

OHIO Medical Association

Colleagues in the News

WILLIAM A. ALTEMEIER, M.D., Cincinnati, has received the Harvey Stuart Allen Distinguished Service Award of the American Burn Association. The award is presented annually to an outstanding United States scientist for his contributions in the field of burns. Professor of Surgery and Director of the Department of Surgery at the University of Cincinnati College of Medicine, Dr. Altemeier is President-Elect of the American College of Surgeons.

Three members of the Medical Staff of Riverside Methodist Hospital, Columbus, have recently passed the board examination in cardiology: **RICHARD CANDELA, M.D., MAO-HSUING CHEN, M.D.,** and **JOHN HUSTON, M.D.**

GEORGE CRILE, JR., M.D., Clinical Emeritus Consultant at the Cleveland Clinic, has been awarded honorary fellowship in the Royal College of Surgeons in England. This marks the first time in the history of the College that the honorary fellowship has been bestowed on a father and son. Dr. Crile's father, a founder of the Cleveland Clinic, was so honored in 1913.

Numerous members of the Youngstown medical community have been certified by boards of various medical specialties. Included in this group are **F. W. DUNLEA, M.D., D. H. LEVY, M.D.,** and **ASHER RANDALL, M.D.,** recertified by the Board of the American Academy of Family Practice; **JOHN C. MELNICK, M.D.,** certified by the American Board of Nuclear Medicine; **DAVID E. PICHETTE, M.D.,** certified by the American Board of Urology; and **GEORGE L. RIVER, M.D.,** certified in medical oncology by the American Board of Internal Medicine.

HENRY J. HEIMLICH, M.D., Cincinnati, has been appointed Professor of Advanced Clinical Sciences at Xavier University, Cincinnati. Known for developing the Heimlich Maneuver, Dr. Heimlich founded the Dysphagia Foundation and served as president of the National Cancer Foundation for five years. Prior to accepting the position at Xavier University, Dr. Heimlich was Director of Surgery at Jewish Hospital.

HENRY HOLDEN, M.D., has been installed as President of the Clinical Staff of the Youngstown Hospital Association. Dr. Holden is a member of the division of internal medicine and is a past president of the Mahoning County Medical Society. Other officers include **JOHN J. TURNER, M.D.,** president-elect; and **ROBERT G. WARNOCK, M.D.,** secretary-treasurer. Immediate past president is **EDWARD A. SHORTEN, M.D.**

CHARLES M. KLEIN, M.D., Sylvania, has been elected President of the Northwestern Ohio Radiological Society. Other officers include **JAMES JAGODZINSKI, M.D.,** Toledo, president-elect; and **PREM C. CHANDNANI, M.D.,** Toledo, secretary-treasurer.

JOHN M. TEW, JR., M.D., Cincinnati, has been elected Chairman of the Section of Cerebrovascular Surgery of the American Association of Neurological Surgeons. Dr. Tew is a founding member of the section whose major projects include national studies of new techniques and drugs for the treatment of strokes.

RUPERT B. TURNBULL, JR., M.D., Cleveland, received the honorary fellowship award of the Royal Australian College of Surgeons. This award is the highest honor the College can bestow on any surgeon outside its organization. Based in Melbourne, Australia, the College represents surgeons in Australia and New Zealand. Dr. Turnbull was appointed to the staff of the Cleveland Clinic in 1950 and served as head of the Department of Colon and Rectal Surgery until 1976, when he was named senior surgeon of the department.

RICHARD W. VILTER, M.D., Cincinnati, has been named President-Elect of the American College of Physicians. Professor of Medicine and Director of the Department of Internal Medicine, University of Cincinnati College of Medicine, he has served the American College of Physicians as governor for Ohio, member of the Board of Regents, and secretary general. At the University of Cincinnati, Dr. Vilter is the Gordon and Helen Hughes Taylor Professor of Internal Medicine in the College of Medicine and at the University of Cincinnati Hospital. He joined the faculty in 1942 and became department director in 1956.

Dr. Vilter's career-long interest in hematology and nutrition was recognized in 1960 when the AMA presented him its Goldberger Award for outstanding contributions in the field of nutrition.

"Colleagues in the News" is sponsored by

Blue Shield

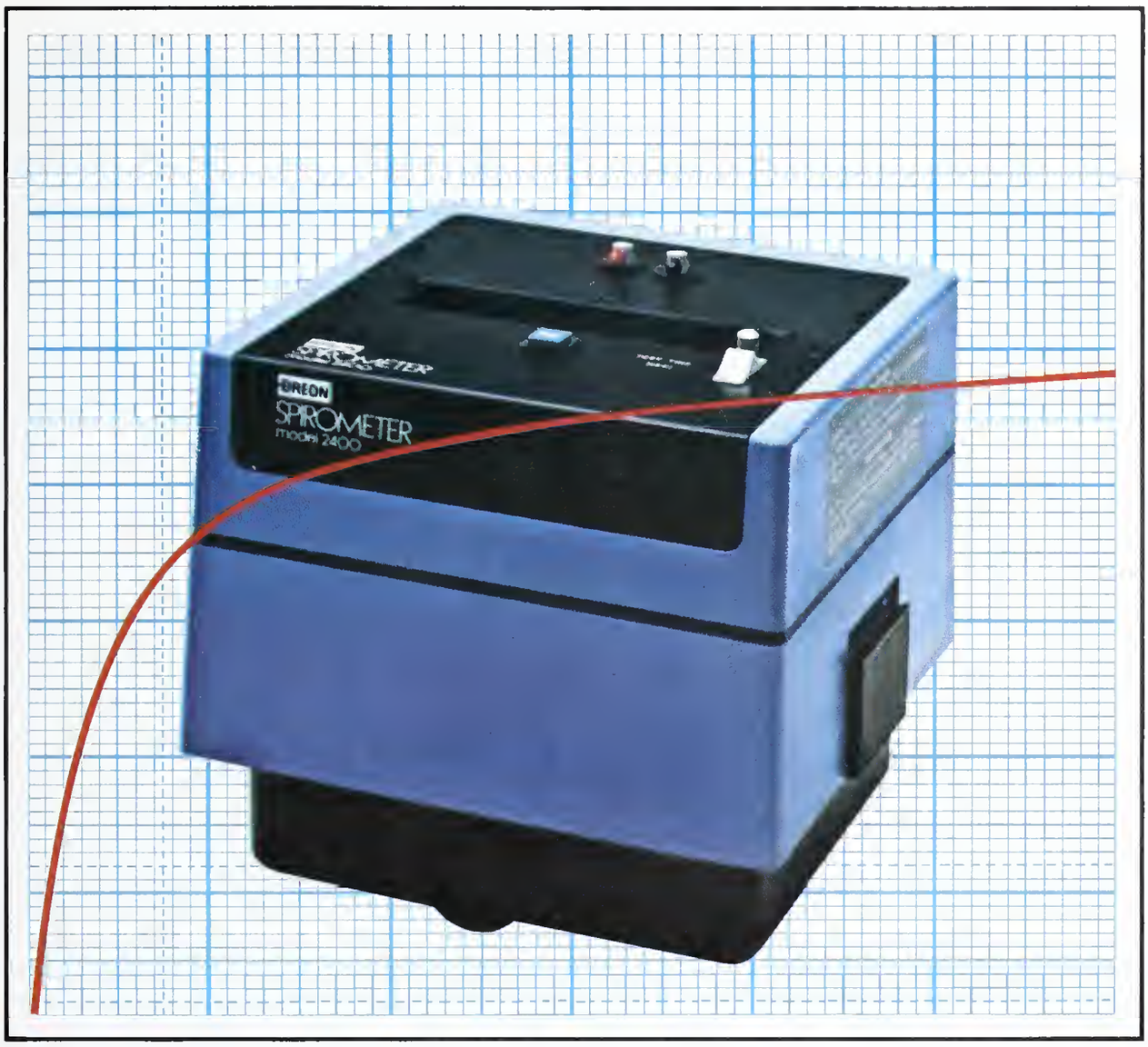
Ohio Medical Indemnity, Inc.

6740 North High Street, Worthington, Ohio 43085

(614) 438-3500

(PAID ADVERTISEMENT)

SPIROMETRY MADE SIMPLE



Introducing the **BREON**
SPIROMETER
MODEL 2400

- Positive Displacement Direct Reading Spirometer
- Simple to Use
- Easy to Interpret

For more information send in this postage-paid card.

First Class
Permit No.
59720
New York, N.Y.
10016

BUSINESS REPLY MAIL
No postage necessary if mailed in the United States

Postage will be paid by:

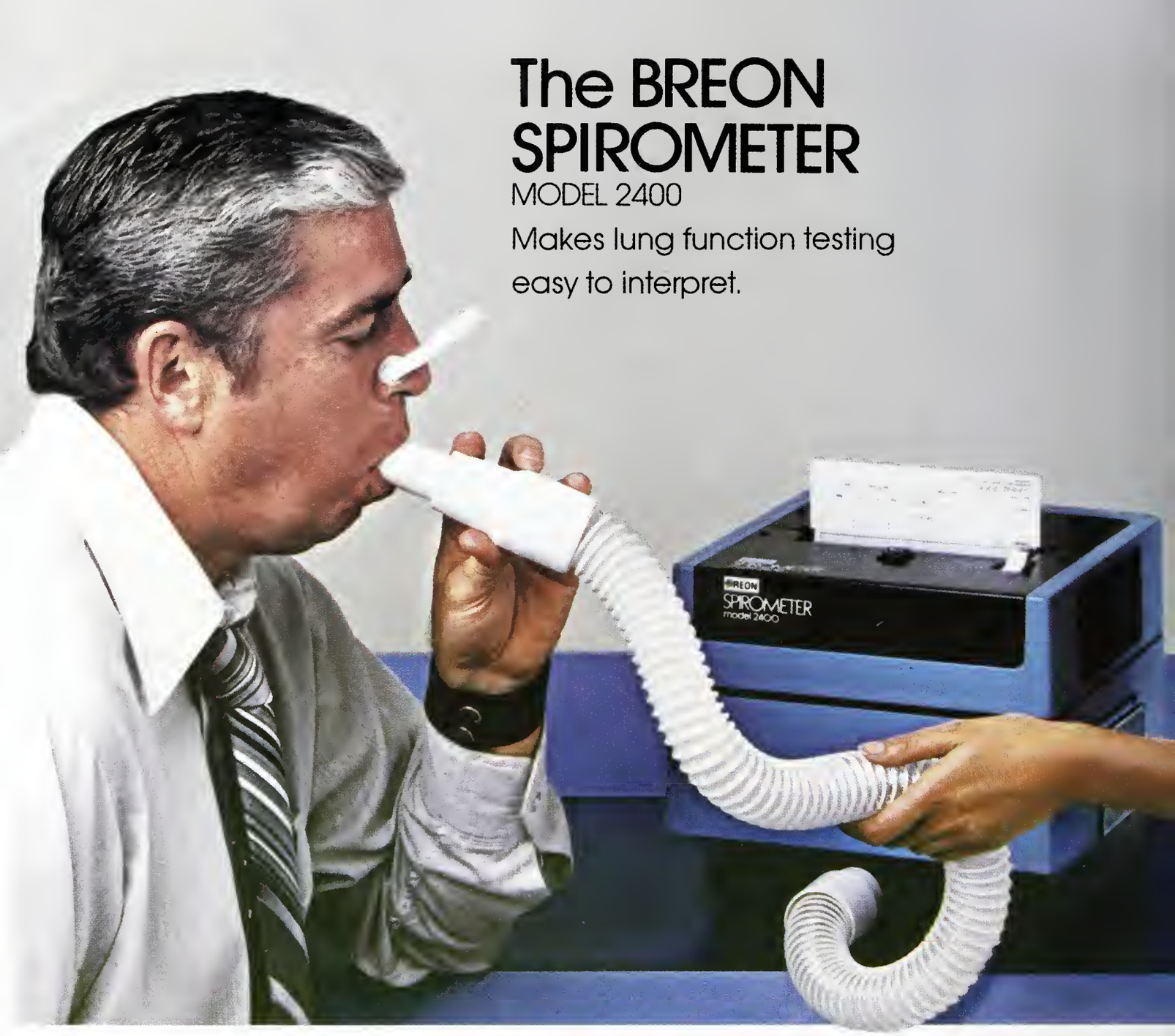
Breon Laboratories Inc.
90 Park Avenue
New York, N.Y. 10016

Attn: M. Trepicchio

The BREON SPIROMETER

MODEL 2400

Makes lung function testing easy to interpret.



- Provides a permanent record of results
- A single test provides most common and useful readings.
- ±1% accuracy at full scale
- Weighs less than 10 pounds
- Economical to use

I'd like to know more about office spirometry and the **Breon SPIROMETER Model 2400.**

☐ Please send me more literature.

☐ Please have your representative call.

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____

For more information send in this postage-paid card.

BREON

Breon Laboratories Inc.
90 Park Avenue
New York, N.Y. 10016

Disability Insurance for Physicians

J. Harry Mosher, CLU

MAN'S BASIC NEEDS are few: food, water, shelter, air, sleep, and freedom from pain. In the Western World, mankind enjoys an abundance of goods and services with little concern except freedom from pain. Although the medical profession is dedicated to the prevention and minimization of pain, accidents and sickness continue to cause suffering and often economic loss. According to O.D. Dickerson, economic loss is an involuntary parting with value. These losses create a decrease in either the value of human life or property.

In 1924, Dr. S.S. Huebner developed the concept of man's earning ability as a capital asset, which he called the human-life value. This value can be expressed in dollars as they represent the capitalized value of the individual's ability to earn an income. The capital value of the human life can be destroyed by: (1) premature natural death— dying too soon or (2) economic death— disability due to superannuation, sickness, or violent injury. Such economic losses are subject to scientific treatment through the insurance mechanism.

Physicians purchase sizable amounts of life insurance to provide for their dependents in the event of a premature death. Yet, many neglect to purchase adequate insurance to provide for the same dependents if the physician becomes disabled. The disability probability compared with the death probability per 1,000 lives exposed is shown in Table 1. The probability of at least one long-term disability that lasts at least 90 days in a group of one to six men is shown in Table 2.

Amounts of Disability Insurance

A prudent physician will purchase disability insurance in amounts necessary to provide the standard of living he desires for his family. There are no maximum-benefit limits imposed by the Internal Revenue Service or by Ohio statutes; however, all insurance companies have their own underwriting rules which limit the indemnity they will offer. These rules usually restrict the indemnity to a percentage of earned income, such as 40% to 66⅔%, depending upon the company, and may include a maximum-dollar limit in which they will participate with other companies, such as $5,000 monthly. The participation limits usually decrease as earned income increases, recognizing the graded federal income tax. Maximum-dollar limits in which one company will offer or participate with other companies discourages malingering.

Sources for Disability Insurance

A physician may purchase disability insurance through his professional association, such as the Ohio State Medical Association, or from an insurance company which offers individual policies and group policies.

Association Plans.— Most association plans are franchise plans which were designed to provide some of the advantages of both group and individual coverage. The chief differences between franchise and individual coverage are the availability of a discount rate and the renewal agreement. The insurance company underwrites each risk individually, usually without a medical examination, and it may reject any application or attach limiting waivers on any policy. Frequently, the insurance company has the option not to renew all insureds on the policy anniversary and has the right to adjust the premiums. An exception is the plan sponsored by the Ohio State Medical Association which is guaranteed renewable to age 70 years, as long as the Association sponsors and supports it and the member is actively engaged in his profession on a full-time basis.

Individual Policies.— Most companies' individual policies are noncancellable, which gives the insured the unqualified right to continue the policy in force for a substantial period of time by reason of the payment of

TABLE 1. Probabilities of Disability vs Death per 1,000 Lives Exposed*

Attained Age (Years)	Disability of 90 Days or More (%)	Death at Age Indicated (%)	Ratio of Disability Probability to Death Death
22	6.64	0.89	7.46
27	6.57	0.98	6.70
32	7.78	1.18	6.59
37	9.81	1.68	5.84
42	12.57	2.95	4.26
47	16.76	4.91	3.41
52	22.39	8.21	2.73
57	31.10	13.22	2.35
62	44.27	21.22	2.10

*Source: O. B. Dickerson, *Health Insurance*, Third Edition, p. 16

Mr. Mosher, Columbus, is Vice President, Turner and Shepard, Inc., a general insurance brokerage agency specializing in insurance programs for professional persons throughout Ohio.

Table 2. Probability of One Long-Term Disability Lasting at Least 90 Days in Groups of Men*

Age (Years)	Period (Years)	Number in Group					
		One %	Two %	Three %	Four %	Five %	Six %
25	40	53.7	78.6	90.1	95.4	97.9	99.0
30	35	52.2	77.1	89.1	94.8	97.5	98.8
35	30	50.3	75.3	87.7	93.9	97.0	98.5
40	25	47.7	72.7	85.7	92.5	96.1	98.0
45	20	44.3	69.0	82.7	90.4	94.6	97.0
50	15	39.4	63.2	77.7	86.5	91.8	95.0
55	10	32.1	53.8	68.6	78.7	85.5	90.2
60	5	20.4	36.6	49.5	59.8	68.0	74.5

*1964 Commissioners Disability Table

premiums agreed upon in advance. According to the National Association of Insurance Commissions, for a policy to be called noncancellable, it must have three characteristics: (1) the absence of a cancellation clause (2) the right of renewal and (3) the guarantee of premium rates. The definition of disability is usually more liberal than any available in franchise or group plans.

Group Plans.— True group plans are available without evidence of insurability to employers of ten or more individuals. Usually, it is written on an annual basis with renewal at the option of the company. The insurance company may adjust the premium, and the benefits often are reduced by the amount of any benefit received from Social Security or Workers' Compensation. A master policy is issued to the policyholder, normally the employer; and each employee receives a certificate which is a summary of the master policy.

Taxation of Disability Insurance

Premiums paid on personal disability insurance are not deductible as a business expense, but the proceeds are tax exempt as compensation for personal injuries or sicknesses (IRC 55-331).

Premiums paid by a corporation are tax deductible (IRC Section 162), and the premiums are not reportable as compensation by the employer (IRC Section 106). The effect of the 1976 Tax Reform Act requires all benefits received by an insured with annual gross income in excess of $20,200 to be taxed as ordinary income when a corporation pays the premium.

Split-Dollar Disability for Corporations

If the insurance premium is shared by the employer and the employee, the exclusion limits apply only to that portion of the disability income resulting from the employer's premium payments (IRC 73-347). Therefore, a physician may let the corporation pay the premium contributable to one year's benefits and then he/she pays the balance with after-tax dollars. In the event of a claim, all benefits received after one year would be tax free.

For example, at age 40 years, the annual cost of the OSMA-sponsored Disability Income Protection Plan is $478 for a $1,000 monthly benefit payable until age 65 years for an illness, or payable lifetime for an accident. A $1,000 monthly benefit, payable for only one year for both accident and sickness, costs $362.50 annually. If the corporation would pay the $362.50 annual cost and the physician paid the difference with after-tax dollars, all benefits received after one year would be tax free.

Specialized Coverages

Business Overhead Expense is a special disability policy which reimburses professional persons for overhead expenses actually incurred during periods of disability. Most companies will offer this in addition to personal disability insurance. The premiums are deductible as a business expense, and the proceeds are taxable (IRC 55-264).

An IRS letter ruling dated October 27, 1971 holds that the benefits payable to the corporation are includable in the corporation's gross income, and the premiums paid by the corporation are deductible as a business expense.

Disability in the Buy-and-Sell Agreement.— Many buy-and-sell agreements are funded with life insurance, but have no funding provision in the event of a disability. Several companies now offer a special disability policy which can be written in addition to personal disability for this purpose. Some of the points to consider are when should the buy-out be mandatory, when is a stockholder disabled, and should payment be a lump sum or in installments.

Your Best Buy

A physician enjoying a good income from his practice will find it necessary to buy more than one policy because of the insurance companies' underwriting limits. Companies offering individual policies usually have low participating limits of from 40% to 55% of earned income, while franchise insurance available through associations or group insurance will supplement this coverage up to 66⅔% of earned income.

An insurance advisor should be selected who has available to him association, individual, and true group disability policies. A professional insurance consultant will recommend a combination of those plans best suited for his clients in an attempt to uphold the Chartered Life Underwriters (CLU) Pledge:

> I shall, in the light of all the circumstances surrounding my client, which I shall make every conscientious effort to ascertain and to understand, give him that service which, had I been in the same circumstances, I would have applied to myself.

THREE-IN-ONE THERAPY AGAINST TOPICAL INFECTION



Neosporin® Ointment

(Polymyxin B-Bacitracin-Neomycin)

This potent broad-spectrum antibacterial provides overlapping action to help combat infection caused by common susceptible pathogens (including staph and strep). The petrolatum base is gently occlusive, protective and enhances spreading.

Neomycin

Staphylococcus
Haemophilus
Klebsiella
Aerobacter
Escherichia
Proteus
Corynebacterium
Streptococcus
Pneumococcus

Bacitracin

Staphylococcus
Corynebacterium
Streptococcus
Pneumococcus

Polymyxin B

Pseudomonas
Haemophilus
Klebsiella
Aerobacter
Escherichia

In vitro overlapping antibacterial action of Neosporin® Ointment (polymyxin B-bacitracin-neomycin).

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Neosporin® Ointment

(Polymyxin B-Bacitracin-Neomycin)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

There is a better way to do it... You can find it!

Two New Books Now Available -

PERSONNEL POLICIES AND PROCEDURES FOR THE MEDICAL OFFICE

Do you have personnel policies? Are they written? Are they up to date? Do they provide a clear, concise, competitive statement of what you offer and what you expect from your employees? Are your policies within the guidelines of recent legislation?

- Tells the employee what to expect on these important topics:

Working hours	Personal appearance	Vacation	Outside employment
Holidays	Personal phone calls	Housekeeping	Personal medical care
Smoking	Civic responsibilities	Parking	Compassionate leave

- Reviews policy topics for the manager in depth.
- Prewords sample policies for you on 23 topics.
- Makes you aware of many employer obligations such as:

Sick leave	Medical &	Salary	Summary dismissal
Personal days	dental appointments	Discipline	Other benefits
Probation	Performance review	Termination	Leave of absence



AN EASY WAY TO WRITE PERSONNEL POLICIES!

*

APPOINTMENT SCHEDULING THAT WORKS!

A course in appointment scheduling that enables your medical assistant to rebuild your scheduling system – according to the way you work.

- Your appointment employee learns about your real problems as she explores the improvements.
- The resulting schedule is custom designed for your specialty – the way you do things.
- Respects the patient's time. Keeps him from waiting more time than is reasonable - (usually 20 - 30 minutes maximum).
- Begin getting home on time.
- The workbook becomes a portfolio for continued improvement in future years.
- A simplified "Systems Analysis" approach to an age old problem.



A NEW APPOINTMENT SCHEDULE FOR YOU!

Practice Productivity Inc. **Management Consultants to Physicians**

Please send:

_____ copies of Personnel Policies and Procedures For the Medical Office at $24.50 + $1.80 for shipping and handling:Total $26.30.

_____ copies of Appointment Scheduling That Works! at $14.95 + $1.60 for shipping and handling: Total $16.55.

Send to:

Name _____ Telephone ( ) _____

Practice Name _____ Specialty _____

Address _____ No. of Doctors _____

City _____ State _____ Zip _____ No. of Employees _____

Bank Americard or Master Charge No. _____ Expiration Date ____/____Signature _____

Allow 2 - 3 weeks for delivery. Make check payable and send to:

PRACTICE PRODUCTIVITY INC., 2000 Clearview Avenue, Atlanta, Georgia 30340 (404) 455-7344

Physicians' Office Records: Some Medical-Legal Considerations

James E. Pohlman, J.D.

THIS ARTICLE DISCUSSES the legal and practical considerations concerning the maintenance and use of physicians' medical records. Given the ever-present potential for professional liability claims and litigation, the physician's office medical records, depending upon how accurately, completely, and professionally they are generated and kept, may become either the strongest shield for the defense or the most dangerous sword in the hands of the plaintiff's lawyer. This article will have served its purpose if, in any small measure, it helps to produce more shields and fewer swords.

Legal Function of Records

Medical records can perform several vital legal functions for the physician. First, they serve as a memory aid to the physician. Professional liability claims may not be asserted for months or even years after the alleged incident, and the trial of the case may take place even longer after the original incident. Between the incident and the time of trial, most physicians will have seen literally thousands of patients. Without records to refresh his/her recollection, the physician may have no way of recalling the incident in which the injury allegedly occurred. Ironically, such lapses of memory often occur in cases in which the patient's claim is without merit. If nothing unusual occurs during the course of treatment, there is less reason for the physician to have a specific recollection of an event upon which the patient later asserts a claim.

This memory aid becomes more important in view of the fact that the patient is less likely to be working under the same disability. The patient turned plaintiff can be expected to have, or to claim to have, a vivid memory of the details of treatment and other aspects of the professional relationship. Medical treatment is often an extraordinary event or series of events in the patient's life. Moreover, if the patient's recollection is only partial, he might, even without consciously lying, "fill in the gaps" with imaginary details unfavorable to the physician. To counteract the favorable impression which may be created by a patient testifying with reasonable certainty, the physician will need all the details of the incident he can muster in order to refresh his recollection and give convincing testimony.

Second, medical records prepared by the physician in his office may serve as persuasive evidence. Under Ohio law, a medical record generated by a physician in his office or in a hospital may be introduced into evidence if the custodian of the record or the person under whose supervision it was prepared identifies it and if the record was prepared at or near the time of the event which it records.[1] Thus, even if the physician has no specific recollection of the alleged incident, he can frequently offer his medical records as evidence to show that he acted properly and in accordance with the relevant standard of care.

Contents of Records

Obviously, medical records can be useful only if they are complete, accurate, and kept in accordance with standards of good medical practice and personal integrity. Vague or illegible notes which are only understandable to the attending physician may be of little or no value as evidence, much less be of assistance to other physicians. Ideally, medical records should document every test, diagnosis, and treatment performed for the patient.

It should be remembered that the records generated by the physician will ultimately become available to the lawyer representing the patient plaintiff. Therefore, great care should be exercised with regard to what the physician puts into the medical records. Obviously, the physician should refrain from making derogatory comments in the record either about the patient or other physicians participating concurrently or previously in the care of the patient. However, lack of cooperation in treatment on the part of the patient should be noted.

When an incident occurs, it should be carefully, but fully and truthfully, described in the record. If any corrective steps are taken, they should also be reported. If the incident is serious and obvious, it should be noted without further comment. However, whatever the nature or effect of the incident, nothing should be put into the record which admits or attributes fault. Under no circumstances should an attempt be made to alter, to

Mr. Pohlman, General Counsel for the Ohio State Medical Association, is a partner of the Columbus law firm of Porter, Wright, Morris and Arthur.

destroy, or to falsify medical records. Such action is not only unethical and reprehensible but also futile.[2] Recent political history has proved that a cover-up unraveled can be much more damning than the underlying fault sought to be concealed.

Two Other Important Types of Office Records

It is also important that two other types of office records be regularly maintained. One of these is records of patients' informed consent to dangerous procedures. The nature of and requirements for informed consent, which are discussed fully in two previous articles published in *The Ohio State Medical Journal,* are beyond the scope of this article. (See generally, Mulgrew and Pohlman: "Informed Consent: The Doctor's Dilemma & H.B. 682" in *The Journal,* vol. 72, p 210, 1976, and Mulgrew: "Three Changes in Ohio Law that Affect Physicians" in *The Journal,* vol 73, p 800, 1977, for a fuller discussion of the requirements for informed consent.) However, the importance of a written record of informed consent cannot be exaggerated.

Another important aspect of record keeping is the creation of a record documenting the termination of the physician-patient relationship so that the physician can avoid liability for abandonment. In Ohio, if a physician has undertaken a course of treatment of a patient, he may not withdraw his services at will. Instead, he must give his patient an opportunity to obtain adequate medical care elsewhere before he terminates his professional relationship with that patient. If the physician fails to give his patient an adequate opportunity to find medical care elsewhere, the physician may have abandoned his patient and may be liable for injuries sustained by the patient as a result of that abandonment.[3]

Thus, if the physician decides to terminate the relationship for any reason after a course of treatment has been begun, he should make a careful record of the circumstances of that termination. He should document the time at which the patient was given notice of the projected termination and the length of time during which treatment was continued while the patient was on notice of the projected termination. Furthermore, he should note any assistance rendered to the patient in finding another physician. A form for letters which can be used to notify patients and to create such records is printed in *Medicolegal Forms,* American Medical Association, Office of General Counsel, Form A-1, p. 3 (1973).

Retention of Records

Once complete and accurate records have been established, they must be kept available for future use in order to serve their purposes adequately. If practicable, they should never be discarded since old claims, even if subject to the statute of limitations, do not die easily. And, as discussed herein, the older the claim, the greater will be the need for accurate records. If as a practical matter records must be discarded, they should not be destroyed until after claims which may arise out of the treatment they document have probably been barred by the statute of limitations.

In Ohio, the statute of limitations for malpractice claims (including medical malpractice) is one year.[4] However, the time at which the "one year" begins to run is governed by judicial interpretations which, in some cases, extend the running of the statute well beyond the one-year period after the incident in which the alleged malpractice took place.*

A 1975 amendment to the statute modified the period in which an action may be commenced. Am. Sub. H.B. 682 (1975) amending Ohio Rev. Code §2305.11 placed an absolute limit of four years from the date of the alleged negligence upon the commencement of actions upon medical malpractice claims for adults. For children under the age of 10 years at the time of the alleged negligence, legal action must be begun before the child involved passes his 14th birthday.

Although basic language, recent amendment, and various judicial interpretations have created a rather complex situation concerning the statute of limitations, as to medical malpractice claims, nevertheless, it is possible to set down relatively simple rules of thumb for the retention of medical records. Under the present law, records should be held until the patient reaches age 15 years or until five years after the date of termination of the physician-patient relationship, whichever is later. For the period prior to the effective date of the statutory amendment (July 28, 1975), a slightly different rule applies. Because the amendment may not apply to that period, it is impossible to set a definite length of time after which all claims arising from that period will be barred by the statute. However, for records made prior to the amendment, it is relatively safe to discard documents five years after the termination of the physician-patient relationship or after the patient reaches age 20 years, whichever is later.†

**Gillette v. Tucker,* 67 Ohio St. 106, 65 N.E. 865 (1902), held that the one-year period for statute of limitations does not begin to run until the date of termination of the physician-patient relationship. *Melnyk v. Cleveland Clinic,* 32 Ohio St. 2d 198, 290 N.E. 2d 916 (1972), held that in cases in which foreign objects were left in the bodies of patients during surgery the one-year period does not begin to run until the foreign object is discovered or, with the exercise of reasonable diligence, should have been discovered.

†Note that in a few cases the "foreign object discovery rule" may extend indefinitely the period before the statute of limitations runs. (See previous footnote.) Furthermore, in unusual cases in which the patient is under legal disability because of unsound mind or imprisonment, the statute does not begin to run until he is freed or restored to sanity (Ohio Rev. Code §2305.16, Page Supp. 1976). Therefore, records of patients treated prior to the amendment to whom these rules might apply should be held indefinitely for greatest safety. For a full analysis of the relationship of the original statute, its amendments, and the relevant judicial interpretation, see 38 *Ohio State Law Journal* vol. 1, p 125, 1977.

In addition, it should be noted that medical records are the property of the physician.[5] Thus, the physician is not under any duty to his patient to surrender his original records. Moreover, he should not give up his records unless compelled to do so by a medical emergency, since the records might be damaged, lost, destroyed, or altered by the patient.

Nonetheless, the patient does have a right under Ohio law to inspect and to copy his own records.[6] Although the question has not been decided in Ohio, it is widely held that a physician has a right to refuse to allow a patient to see his records if there is a compelling medical reason for doing so. However, if the physician asserts this right and the patient brings a legal action to force disclosure of these records, the physician will have the burden of proving that the compelling medical reason exists.*

Conclusion

Careful record keeping allows the physician an incomparable opportunity not only to practice sound medicine but also to create the basis for his own defense in any subsequent malpractice litigation. In some cases, well-kept records in and of themselves may be sufficient to defeat a nonmeritorious claim. In nearly all cases, they will be of invaluable assistance in the preparation of a thorough and complete defense.

Acknowledgment: Ralph E. Dill, an associate of Porter, Wright, Morris and Arthur, assisted in the preparation of this article.

References

1. Ohio Rev Code §2317.40 (Page Supp. 1976).
2. Cockrell JV: Suggestions for avoiding malpractice suits. *Am Surg* 27:152-154, 1961.
3. *Morningstar v. Jones,* 31 Ohio L. Abs 440 (Ct. App.) 1940.
4. Ohio Rev. Code, §2305.11 (Page Supp. 1976).
5. 42 Ohio Jur. 2d Physicians and Surgeons §106, p 625 (1960).
6. *Wallace v. University Hospitals of Cleveland,* 82 Ohio L. Abs 257, 164 N.E. 2d 917 (C. P. Cuyahoga Cty., 1959), mod. 84 Ohio L. Abs 224, 170 N.E. 2d 261 (Ct. App. 1960), appeal dismissed 171 Ohio St. 487, 172 N.E. 2d 459 (1961).

*See also, *Opinions and Reports of the Judicial Council,* American Medical Association §5.61, p 27 (1977). N.B., a bill now pending in the Ohio General Assembly (Am. Sub. S.B. 202) would, if enacted, impose upon hospitals, but *not* physicians, the duty to make hospital records available to patients upon request unless there is a compelling medical reason for not doing so.



The Insurance Puzzle: Assembling the Pieces for the Physician's Personal and Professional Protection

David L. Rader

IN TODAY'S ECONOMIC CLIMATE, it is important that the physician have the protection of an integrated insurance program which provides adequate coverage for each exposure to loss. Given the complex nature of the physician's loss exposure, this is not an easy feat. The challenge is heightened by the inability of most insurance organizations to offer a complete and integrated program that is appropriate for physicians. As a result, many physicians have a number of policies with a variety of insurance companies, which can mean overlapping coverage, serious gaps in protection, several policy renewal dates, higher total premiums, and a generally confusing and ineffective insurance program.

The first step in solving this insurance puzzle is to determine what coverages are essential. Protection against claims that may arise out of the performance of professional services is at the top of this list.

Medical Professional Liability Coverage

The need for medical professional liability insurance is well established. Today, few physicians are willing to practice without this coverage, which protects against claims resulting from patient injury during the rendering of professional services.

There are two types of medical professional liability policies: occurrence and claims-made. Most physicians prefer the occurrence policy, which covers claims arising from professional services rendered during the policy period, regardless of when the claims are actually filed. A claims-made policy covers only those claims filed during the time the policy is in effect. Upon termination of a claims-made policy, physicians must purchase "tail coverage" if they want protection against any subsequent claims.

Policy limits are expressed in terms of total dollars payable per claim and maximum aggregate dollars payable for all claims in one policy year. Generally, the basic or primary limits are $100,000/$300,000, although some insurers offer $200,000/$600,000 limits as an alternative. Certain companies also offer excess coverages of up to $1 million per policy year.

Individual premium rates vary according to the physician's specialty. As a result of claims experience, premiums also vary in different parts of the nation and from one insurance company to another. Initially, premiums for claims-made policies tend to be lower, yet the cost of tail coverage charged at a later date may result in total premiums that far exceed the cost of an occurrence policy.

Traditionally, premiums for partnership or corporate coverage have equaled 20% of the aggregate annual premiums of all members of the partnership or corporation. (The Physicians Insurance Company of Ohio [PICO] recently has eliminated this charge on primary coverage if all members of the entity are individual PICO primary policyholders.)

During the past decade, the lack of availability of medical professional liability insurance protection created coverage problems for many physicians. Recently, insurers that had withdrawn from some markets or had reduced their exposures in various ways have again initiated sales efforts. This should enable the physician to become more selective in choosing policy and coverage limits at competitive rates. The inclusion of certain desirable policy features, including physician participation in claims settlements, and special policyholder services, such as premium financing, should also be major factors in the physician's selection of an insurer.

Physician's Office Insurance

Insurance protection for a physician's office should cover medical and surgical equipment and instruments, including tools, materials, supplies, and scientific books;

Mr. Rader, Columbus, is Vice President/Secretary of Physicians Insurance Company of Ohio, a company currently offering office protection, homeowner's, family automobile, professional liability and life insurance to members of the Ohio State Medical Association.

office furnishings and fixtures; the building, if owned by the physician; and liability arising out of the ownership, maintenance, or use of the physician's building, whether owned or leased. Other desirable office insurance coverages include protection against loss of earnings, loss of rents, and personal injury.

While all these coverages are essential, office liability protection is particularly significant. If a physician has office liability with one insurer and professional liability with another, a dispute over which policy applies to a specific claim may result in costly, time-consuming litigation. Insurance experts agree that, if possible, office liability coverage and professional liability coverage should be purchased from the same insurance company.

Most property and casualty insurance companies can provide the appropriate office insurance coverages. Ideally, the physician should select one policy that incorporates all of these coverages. This will eliminate gaps in protection and generally will result in more protection for the premium cost.

Homeowner's Insurance

Loss related to the physician's home may be considered personal rather than professional exposure. Nonetheless, a home is part of the physician's assets and should be fully protected.

Homeowner's insurance is provided by combining several separate coverages in a single policy. The physician may select one of the several homeowner's "forms" that have been developed to meet varied situations. All homeowner's forms are identical in the scope of property covered; the difference is in the perils that are covered.

Homeowner's Form No. 1, considered the basic policy, covers loss from fire and lightning, damage by vehicles, damage from explosion, theft, and certain other basic risks. Form No. 2 adds such perils as weight of ice, snow, or sleet, freezing, and falling objects.

Form No. 3 is termed "all risk" and covers all risks except those specifically excluded in the policy, such as war and nuclear explosion. This is the most popular form because of the high degree of coverage provided for the cost.

Form No. 4 is designed for apartment dwellers and covers contents only.

Form No. 5 is similar to the all-risk No. 3 but is more expansive and thus more expensive. Form No. 6 has been designed for condominum owners.

Homeowner's policies have been standardized throughout the insurance industry. The most important considerations are selecting the most appropriate form, making sure the rates are competitive, and checking the company's claims and policyholder services.

Family Automobile Insurance

Like homeowner's insurance, automobile insurance has become highly standardized. Selection of appropriate coverages, evaluation of the quality of service provided, and competitive rates are primary concerns.

The physician should have physical damage protection, liability coverage, protection for medical services expenses, and uninsured motorist coverage. The insurer should offer multi-car discounts, driver-training credit, good-student credit, and safe-driver discount.

Completing the Puzzle

These are the physician's essential property and casualty insurance coverages: professional liability insurance; office protection insurance, including premises liability; homeowner's; and family automobile. Depending upon the physician's personal situation, there may be need for farmowner's and ranchowner's insurance, recreational vehicle insurance, general liability, or commercial package insurance. A reputable, professional insurer will provide these and similar forms of protection at competitive rates through policies that are regulated by state insurance laws.

However, few insurance firms have chosen to provide all of these forms of protection. The physician shareholders of PICO believe that the physician should be able to obtain an integrated insurance program through a financially sound, competitive, aggressive company that understands the insurance needs of the medical profession and conducts its business accordingly.

People in a number of other professions have been able to solve their insurance puzzles through the services of a particular insurance organization. Now, these services are available to the medical profession through PICO.

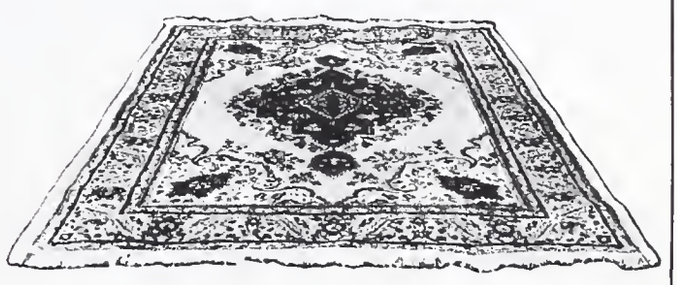
In Columbus
for over 65 years, since 1909,
K. A. Menendian
has been known for
the finest quality and best values in
ORIENTAL RUGS.

We carry a complete selection of rugs from mats to mansion sizes. Over 1500 rugs in stock from Iran, India, China, Pakistan, Turkey, etc.

See over 4,000 samples in our newly remodeled carpet showroom from Karastan and other fine mills.

We specialize in Oriental rug cleaning and repairing.

K.A.Menendian
1090 West Fifth Avenue
294-3345



How the Physician Locates and Finances His Office

Robert G. Rothring, C.P.A.

ONE OF THE EARLIEST and most critical decisions for a physician is the selection of an office. This decision involves determining the amount and type of space, general location, and proximity to hospitals/referring physicians, type of building and accesses to it, whether to own or to lease, and what is the best way to finance an office. Such a decision affects a physician's practice and, therefore, his livelihood immediately as well as for the long term. Primarily directed to assist the younger medical practitioner, this article summarizes the basic criteria that a physician should use in planning for the establishment of an office.

The most critical factors are unknown in the early stages of a decision to locate and finance an office. The factors that provide the financial backbone of the practice are: *office needs* (equipment, furniture, supplies, decorative furnishings, and work space); *practice patterns* (referring physicians, patient market, patient payment profiles, primary admitting hospitals, and practice schedule); and *practice growth* (personnel and type of expertise, level of maximum patient load and the time to reach it, new physician associates, new technical clinical equipment, and outside service requirements). Although these critical factors only become apparent with time and experience, an attempt for reasonable projections must be made in order to make the best judgments and decisions.

The most necessary and prudent factor in the early stages is flexibility. When making all decisions, the physician(s) should attempt to remain as flexible as possible. He/she should not tie up money and other assets for extended periods of time or in a manner that significant costs or penalties are incurred if changes in plans occur. For this reason, most physicians just establishing practice should not construct or purchase a single-practice building or engage in a long-term lease (five years or more).

Mr. Rothring, Cincinnati, is the owner of Professional Management Service, a company providing business and financial management services to physicians.

Location

Location should be considered first when establishing a medical practice. The type or specialty involved will provide the basic guidelines; thus, location potentials will vary somewhat based upon the type of practice. However, certain considerations are common to all practices and should be evaluated carefully. Basically, the areas of concern are: proximity to hospital or hospitals; availability and accessibility for and to patients; and relationship or distance with other professional office buildings. The various assets involved in a practice— time, personnel, patients, and peers— should have easy and efficient access to you and your office practice.

Proximity to Hospitals.— All specialties using hospital facilities must be cognizant of the time required to travel between hospital(s) and the medical office. This is important because time spent driving between these points often is unproductive time. Currently, through enticement of preadmission testing and outpatient diagnostic/treatment programs, the trend is for the hospitals to encourage physicians toward increased use of comprehensive hospital resources— practicing and admitting patients to only that hospital. Therefore, the benefits of establishing a medical office close to the primary hospitals will be conducive to minimizing lost/unproductive driving time to see patients as well as maximizing relationships with the hospitals.

Availability and Accessibility for Patients.— The location should provide the patients with adequate parking facilities and free-flowing roadways to the office and to the hospitals from the office (minimal time spent in traffic jams). In addition, try to provide easy access to related supplies, such as pharmacies, medical laboratories and/or x-ray units. Although not vital unless the specialty is related to elderly patients since most patients travel by private car, a secondary factor would be access to public transportation.

Relationship or Distance with Other Professional Offices. — A physician should consider locating close to or taking space in a medical office complex. The advantages are many, ranging from being close to physicians who will potentially refer you patients or vice versa to getting the benefits of the image provided by the complex itself. The inference here is if the building is well designed, decorated, and maintained, the patients will tend to identify you with an image of quality and organization through your association with the complex.

Space

Once an optimum location has been selected, the physician must determine the amount of space and its use for efficient and smooth operation. Think through such details as: size of patient waiting area (Will the patient be alone or accompanied by someone? Will they be fully ambulatory or in wheelchairs or on crutches?); patient flow and clinical services to be provided (amount of time spent with each patient, number of treatment rooms); work space for office personnel and duties of each; equipment needs; consultation needs; and other specifics of how the practice is to be conducted. The answers will dictate the amount of space and the space layout required, the amount/type of equipment, and the office furnishings and supplies.

Start planning for future growth in the very beginning and cut down as the financial picture necessitates. Develop an optimum rough design of space requirements and planned utilization. This phase of planning will provide the basics for developing cost analysis and budgets. The finished space will offer the patients their first impression or image of you because the physician "lives" there.

Cost

Once the location is chosen and the space/equipment requirements developed, the next step is to review and evaluate costs, considering all existing alternatives. Basically, this decision comes down to evaluating financial and time implications. Does the physician want to purchase land, construct a building, and manage the real estate; or would he rather negotiate a lease, supervise necessary remodeling, and deal with a lessor? The time differences between the two, as well as the financing and legal implications, vary greatly. The amount and type of expert advice required in each decision are also quite different.

The legal and financial obligations of both methods have direct and long-term ramifications. Money spent for expertise in planning, designing, financing, and accounting/taxes will save potentially large expenditures in the future. The necessity for expert advice and counsel cannot be overemphasized. All contracts are legalistic, and all financing for a new or young practice involves a personal pledge or collateral to cover the costs. This is true even if the physician forms a corporation. Therefore, whether involved in a corporation, partnership, or solo practice, a physician should use the expertise of other professionals, if for no other reason than to maximize the protection of existing personal and family assets.

An outline of special considerations when evaluating whether to lease or to buy follows. Each area will be discussed individually, and the most pertinent of each will be covered.

Lease

The degree and number of technical advisors are not as great when negotiating a lease for either office space or equipment as when a building is going to be bought or constructed. Before entering into negotiations for a lease, plan for required office space, utilization and layout, and consideration of growth potential. Lack of this planning may result in leasing space that is immediately inadequate— providing poor patient traffic flow and creating general inefficiency throughout the entire office. Once the review of the leasing alternative is started, the attorney and accountant should be involved. The issues regarding leasing versus buying have become so complex and technical that certain accounting bodies have issued technical pronouncements concerning the reporting of leases. Many problems have been documented where a lease was actually determined to be a purchase; this has financial and tax ramifications.

A lease is a legal document, which consists of many provisions outlining the responsibilities of both the lessor (or owner) and the lessee (or renter). Thorough review and knowledge of these provisions is a must. Items deserving special attention are: (1) length or term of the lease; (2) escalation clauses; (3) escape clauses; (4) leasehold improvements; (5) practice limitations; (6) decorating and recarpeting; (7) time available for office use; and (8) time building is heated and air conditioned.

Length or Term of Lease.— For maximum flexibility, a lease should not be for a term of longer than five years. In a new practice, the shorter the term the better. This will allow actual experience to help decide future needs and contingencies. For the best situation, an option clause should be negotiated to allow the physician to renew the lease at the end of the term, if he desires. Such a clause protects the lessee much more than the lessor. Keep in mind that the lessor usually favors a longer term, but it is better to sign a lease for three years with an option to renew for three years than to sign a lease for a six-year period.

Escalation Clauses.— An escalation clause protects the lessor against inflationary or unexpected rising costs, such as property taxes, utility rates, insurance rates, and maintenance costs. These clauses are becoming more common, and the lessor may be quite justified in passing these costs on to the lessee. Escalation clauses are often tied in with the increases in the Consumer Price Index. As a lessee, it should be clearly stated that the physician pay only for his proportionate space occupied or leased. For example, if space leased is 2,000 square feet in a 10,000-square foot building, the physician should be responsible only for 20% of any escalators.

Escape Clauses.— These protect the lessee by allowing termination of the lease in the event of the lessee's death or disability. Such a clause should be negotiated as it is

very beneficial when the lessor is willing to make such an accommodation. If possible, attempt to include a clause to cover the physician if he would retire or cease to practice for any reason.

Leasehold Improvements.— This can be a significant item in any lease, especially in practices using specialized equipment requiring modifications to the tenant's space (ie, equipment for an orthopedic practice). Such modification must be discussed in the beginning with specific statements of who is responsible for making the modifications. A common way to finance improvements is for the lessor to make the improvements and receive increased rental payments, capitalized at a specified interest rate, for a specific time period; or the tenant may make the improvements and write them off over the period of the lease as "leasehold improvements." In any case, the lease should state who owns the equipment when the lease expires, and that the equipment can be removed if the property is restored to original condition.

Practice Limitations, Redecorating, Available Time, Heating and Air Conditioning.— Review all limitations to make sure that they will not be detrimental to the practice. Determine if the building is open for use at night and on weekends, the hours that the heating and air conditioning will be in operation, and what security is available. The lessor should state what redecorating and recarpeting will be provided at the end of a specified period of time or at the renewal of the lease.

Purchase

As purchasing or constructing a medical office is much more complex than leasing, it requires a high level of expertise and technical advice. The physician should secure advice concerning: *planning* (engineering, construction, cash flow for payback, tax ramifications, choice of materials, amount of required parking, and building codes); *property* (how much, price, easements, and future development plans); *financing* (construction loans, choice of financial institution, mortgage loans); *pricing* (tenants. going rate in area, required payback, and contingency for maintenance and repairs); and *legal problems.*

Construction Period.— Construction loans are available during the construction period. A construction loan has several advantages, including the fact that the lending institution often will assume responsibility for much of the legal work such as reviewing mechanics' liens to make sure they are in proper order. Additionally, the lending institution usually will review the project through the various stages of completion to insure that all work has been satisfactorily completed before issuing a draw or disbursement.

After the completion of the building, the owner will have to negotiate a long-term mortgage loan. In negotiating for a long-term loan, the physician should study thoroughly the ramifications and total costs involved in long-term financing. This involves comparing various terms for the loan, such as 20, 25, and 30 years. It is often shocking to a physician to see the resulting figure of the monthly mortgage payment multiplied by 360 (a 30-year loan). The total disbursement usually is much greater than expected. When a comparison for a 20-year loan or 240 payments is made, a very significant difference is seen in total cost. However, the total cost must be compared with the required monthly payback. If the difference in monthly payment can be met adequately, the decision becomes basic. For example, a $100,000 loan at an assumed rate of 9½% interest will show the following total costs:

For 30 years — $299,430.00 @ $832.00/Month
For 20 years — $221,758.00 @ $924.00/Month

Construction and land costs being very high, one might consider forming a joint venture, but only after a great deal of thought. The best plans may fail if all parties in the group must meet to make every detailed decision. In a joint venture, it is best to designate one individual who will be responsible for these decisions.

Usually, the next question is: "Should the building be operated as a proprietorship or a corporation?" The proprietorship or partnership generally offers the best tax advantages because losses most commonly incurred in the early years can be passed through and deducted by the proprietor or partners on their individual tax returns. The liability of a partnership versus a corporation can be overcome through the purchase of the proper type of insurance. If a partnership is chosen, an agreement should be developed to state what happens if a member withdraws from the partnership or how buy-sell arrangements are to be handled. Expert legal advice is definitely required.

Tedious and time-consuming thought is necessary before reaching the stage of cost comparisons to determine which is the most economical and advantageous method of financing. The final decision for financing an office may involve using both methods of financing, such as leasing the office while buying the equipment and furniture, or even the reverse. A physician should work toward provisions and purchase agreements that will provide direct benefits, such as insuring that the lessor will pass on the investment tax credit to the lessee.

Conclusion

When contemplating establishing a medical office, a physician should consider all factors. Develop a schedule of all costs for both methods of financing, such as down payment for purchase, total cost of payback, payments due at the beginning or end of lease, and any add-on finance charges for purchasing the equipment or building. Get total cost figures for both types of financing and compare the two. Figures may show on a total-cost basis for equipment that outright purchase of equipment will be less costly. However, some front money or down payment plus a personal pledge is required for purchase. Leasing provides the advantage of little or no down payment, which may be more beneficial for a young practice with low cash reserves.

The only way to enter into any of the preceding arrangements is to choose experts for advice and, with these experts, make a thorough, detailed study. Then arrive at a decision based upon the facts.

The Eighth Annual

PERIPHERAL VASCULAR DISEASE Symposium

under the chairmanship of

William E. Evans, M.D.

September 14-16, 1978

at

Saint Anthony Hospital

featuring presentations by:

John Bergan, M.D.
Professor of Surgery and Chief of Vascular Surgery at Northwestern University

Malcolm Perry, M.D.
Professor of Surgery and Chief of Vascular Surgery at Cornell University College of Medicine

Ronald Stoney, M.D.
Professor of Surgery, University of California

H. Brownell Wheeler, M.D.
Professor and Chairman of the Department of Surgery University of Massachusetts

also

Vascular Lab Workshops

$125.00 registration

16 - C.M.E.'s granted

Limited to the first 250 registrants

Mail checks to Mrs. Dale Nelson, Saint Anthony Hospital, 1450 Hawthorne Avenue, Columbus, Ohio 43203

Enclosed is my check for $_____ to cover _____ reservations.

Name _____

Address _____

City _____ State _____ Zip _____

Please check ☐ Send hotel reservation card ☐ Will need transportation between hospital and hotel

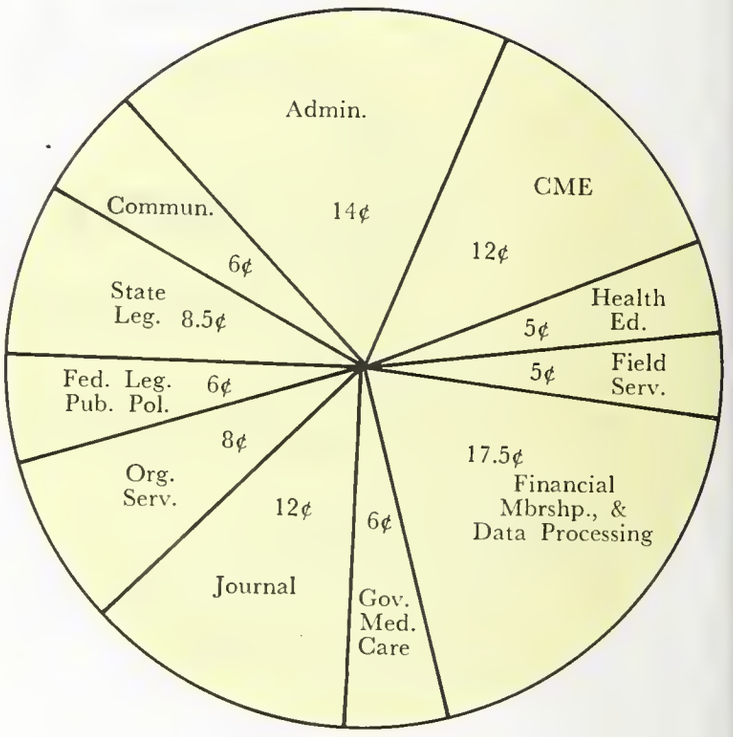
OSMA Membership: You Can't Afford to Be Without It

Robert G. Thomas, M.D.
Katherine E. Wisse

What does your OSMA dues dollar do for you?

The prime goal of the Ohio State Medical Association is to make your work as a physician a bit easier through numerous membership services.

There are approximately 14,000 practicing physicians in the State of Ohio, and 11,500 of these are members of the Ohio State Medical Association. The OSMA has a total budget for 1978 of over $1½ million. This budget supports 11 OSMA departments, each with expertise in a different field, and staff of 36 individuals. The division of the 1978 budget dollar is shown in the Figure.



Division of 1978 budget dollar to each department.

Insurance

One service that both saves you money and assists you in dealing with rising costs is the Association's insurance package. As an OSMA member, you are eligible to participate in disability income protection, major medical, group term life, group ordinary life, and corporate employers' group term life programs. One example of savings is the $500,000 dividend paid to participants in the group term life plan in 1977. This amount covered the semi-annual premium of most policies.

Professional liability insurance also is available to members. In response to the needs of the membership, the Physicians Insurance Company of Ohio (PICO) was formed in 1976 under the auspices of the OSMA. Without PICO, many Ohio physicians would be without malpractice insurance today.

Automobile Leasing

In addition to providing outstanding leasing services, the Association's automobile leasing program has afforded members a significant savings. Also, you can travel throughout the world on OSMA-sponsored tours, complete with deluxe hotel accommodations, meals, and transportation. Most trip packages cost less than commercial round-trip coach air fare.

Communication

The Association tries to keep all members informed through the publications that reach you monthly. Numbered among these publications are *The Ohio State Medical Journal,* the official publication of the Association, which contains scientific and socioeconomic articles of special interest to the physicians of Ohio; *Synergy,* a health-education tool to inform patients; *OSMAgram,* a concise news bulletin which pinpoints items of immediate concern; and *Legislative Bulletin,* a newspaper to keep the OSMA leadership informed of legislative activities.

In 1977, the OSMA mailed an average of 77,000 pieces of mail monthly. This amount was in addition to correspondence to the membership and the public in response to the more than 100 first-class letters that are received daily.

In addition, all departments are kept busy answering questions from members and the public. In an average month, over 1,000 long-distance calls are placed from

Dr. Thomas, Secretary-Treasurer of the Ohio State Medical Association, is a pathologist in Elyria.
Mrs. Wisse, Associate Executive Director and Comptroller, The Ohio State Medical Association.

Association Headquarters. This number does not even touch the number of incoming calls. The Association's eight telephone lines are often used to full capacity handling in excess of 150 calls per day.

The Department of Communications directs its activities at maintaining a positive public image of physicians. Recently, this department has expanded on the activities of the Task Force on Professional Liability, which conducted a public information campaign to determine the attitudes of Ohio citizens toward medicine in general as well as the malpractice situation. Currently, the results of this survey are being disseminated to the media and the public.

Continuing Education

The OSMA both presents and cosponsors continuing medical education programs to enable physicians to meet their 150-hour legal requirement for reregistration of medical license. Through the Department of Continuing Medical Education, the OSMA offered 76 programs last year in all major cities in Ohio.

Records

The Membership Department maintains biographical information and serves as an up-to-date clearing house. In 1978, the installation of a computer system will further enhance the OSMA's ability to store and to retrieve information about Ohio physicians. This department handles 2,000 to 2,500 member address changes annually.

The OSMA offers a Placement Service which assists physicians in locating an Ohio community in which to set up practice. Monthly, this service receives an average of 30 inquiries from physicians and ten from communities seeking medical personnel.

Legislation

Your voice is also heard by the Ohio House and Senate. Of the more than 1,700 bills introduced in 1977, about 140 affected the practice of medicine. Of these, the OSMA took a position on more than 50 and monitored the others. All this effort is generated through the Department of State Legislation.

To bring Ohio-physician opinions to the attention of Congress, the Department of Federal Legislation uses key legislative contacts and the American Medical Association Washington Office. In 1977, Congress considered 30,350 bills of which over 3,000 involved medical and health care. In addition, federal regulations affecting health and medicine and having the force of law were "ground out" by the hundreds in Washington's bureaus and agencies.

Health

Another very important activity is the OSMA Physician Effectiveness Program which was initiated in 1975. It assists physicians beset by personal problems including alcoholism, drug abuse, and mental disorders.

Education of the public in preventive health care in order to help reduce medical costs is also an OSMA priority. The efforts of the Department of Health Education will be intensified through the Ohio State Medical Association Education and Research Foundation established in 1977.

A Final Word

These membership services represent a fraction of all OSMA activities. Can an Ohio physician afford to be without any one of them? This myriad of activities, which are carried on in your behalf, set the climate for your practice of medicine. Whether the benefits are clearly definable to you or not, it is important for medicine to speak with one voice. The improvement of conditions within the medical sphere deserves the support of all physicians.

Your willingness to join with your colleagues in support of your local medical society, the Ohio State Medical Association, and the American Medical Association is the greatest benefit of all— one based on unity of purpose.



WINDSOR HOSPITAL

A NONPROFIT CORPORATION

— ESTABLISHED 1898 —

Chagrin Falls, Ohio

247 - 5300

A hospital for the treatment of Psychiatric Disorders

High on a Hill-Top, Overlooking Beautiful Chagrin River Valley.

Accredited by Joint Commission on Accreditation of Hospitals.

Booklet available on request.

FRIEDRICH A. LINGL, M.D. Medical Director

GUY H. WILLIAMS, JR., M.D. Medical Director Emeritus

HERBERT A. SIHLER Jr. President

MEMBER: American Hospital Association—National Association of Private Psychiatric Hospitals

Legislative Update

the federal scene

(Courtesy the AMA Washington Office and OSMA Department of Federal Legislation)

National Health Insurance Debate Goes On

Congressional debates over the energy crisis, Panama Canal treaties, Social Security tax rollbacks, and income tax reductions got most of the headlines in the first quarter of 1978, but national health insurance (NHI) issues remain quietly active. Senator Edward M. Kennedy, organized labor's champion for its brand of NHI, is reported backing away from his original proposal for total federal domination of health-care financing. While President Carter plans to stick by his campaign promise to labor for an Administration-backed NHI proposal, it has become clear in all quarters that the Health Security Act— the organized-labor-and-Kennedy-sponsored plan— has no chance of passage due to its price tag alone.

This significant strategy change is designed to boost chances for enactment of a NHI bill within the next few years and to place labor in tandem with the Carter Administration on the issue. Soon, the administration is expected to release a position paper staking out the type of NHI plan the President wants approved.

Labor made a strenuous effort earlier to get the Administration to support its Health Security Act; but the Administration balked, telling labor leaders such a plan was too expensive and could not win congressional endorsement. Fearing that NHI was in danger of collapsing altogether unless a united front could be formed, labor leaders and Kennedy went to President Carter with the word they would end their years-long policy of insisting on an NHI plan calling for complete federalization of the financing. Labor now says it will accept a NHI plan that provides a rule for private health insurance carriers, who would have been wiped out under the Health Security Act. Officials of the AFL-CIO and the United Automobile Workers accompanied Kennedy in notifying Carter of the policy reversal.

Whatever plan Carter endorses, it will need all the help it can get. Congress has been shaken by the uproar over increasing Social Security taxes and is reluctant to embark on any expensive new social program at this time due to the fiscal plight of the Treasury and the threat of double-digit inflation.

The American Medical Association immediately branded a White House Wage-Price Stability Council report on soaring physician fees a "political hatchet job." The report said doctor bills are increasing half again as fast as the overall inflation rate and that the situation may get worse. It also accused the AMA of trying to limit the number of doctors in practice.

"The report is built on old data and faulty research," said James H. Sammons, AMA Executive Vice President. "We are incredulous that this unit of the executive branch of the government would publish a press release and summary report that is not substantiated in the body of the report itself."

He said the AMA has actively worked to increase the number of medical schools and practicing physicians in this country. Almost 16,000 doctors are now graduated from U.S. medical schools each year, about double the number of five to seven years ago.

He said the data about physicians' income and fees are incorrect. The study said that two years ago, the median income of physicians was $63,000. The AMA, which publishes yearly statistical studies of medical practices, says the projected median for 1976 is $54,000 and that the actual 1975 median before taxes was $50,337. "That's not even close to the incredible figures being used (in the report)," Sammons stated.

He also criticized the report for the inadequate reporting of facts and statistical data, the inappropriate interpretation of historical information, the use of data to present only partial conclusions on changes in physicians' fees, and the lack of recognition of private initiatives that are working to restrain the rate of increase in overall health care costs.

"The AMA will address other issues in the report as they are analyzed by staff," Dr. Sammons said. "We have not, and will not, avoid the issue of physicians' fees. We have already joined with other segments of the private sector, including physicians, hospitals, and insurers, and have taken steps to seek answers to the overall health care cost question through studies done by the National Commission on the Cost of Medical Care and the 'Voluntary Effort' program."

"But with documents like this being issued by the government," Sammons said, "it looks like we will have to continue bearing the brunt of finding constructive answers ourselves. We hope that the Council's allegations will not be used in an attempt to discredit or destroy these important private initiatives."

The National Commission on the Cost of Medical Care was established as an independent body by the AMA in 1975 and recently issued a report and 48 recommendations for restraining health care costs. The Association will be responding to these recommendations during its 1978 Annual Convention later this month.



COLACE prevents hard, dry stools common to constipation . . . and does it without laxative stimulation. COLACE assists peristalsis by simply letting intestinal water permeate stools.

COLACE helps to prevent painful straining at stool—particularly important in patients with delicate anorectal disorders. Safe and non-habit forming . . . COLACE, the simple water way to ease constipation from infancy to old age.

Simple drops of water help make COLACE® the most widely used stool softener.

COLACE®
dioctyl sodium sulfosuccinate

Mead Johnson
PHARMACEUTICAL DIVISION



Does it influence your choice of a peripheral/cerebral vasodilator*?

- Vasodilan—compatible with coexisting diseases
- Vasodilan—compatible with concomitant therapy
- Vasodilan—compatible with your total regimen for vascular insufficiency

***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.
Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily.
Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.
Parenteral administration is not recommended in the presence of hypotension or tachycardia.
Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.
Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.
Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

U.S. Pat. No. 3,056,836

VASODILAN®
(ISOXSUPRINE HCl)
20-mg tablets

Mead Johnson PHARMACEUTICAL DIVISION

© 1978 MEAD JOHNSON & COMPANY · EVANSVILLE, INDIANA 47721 U.S.A. MJL7-4269

Insuring Honesty in Your Practice

Jack Walsdorf

"I can't believe it! She seemed so dedicated and trustworthy that I had complete confidence in her. I made a mistake . . . a $3,000 mistake."

SO GOES THE TYPICAL physician's lament after the discovery of an embezzlement. Could the theft have been prevented? Probably, if the physician had exercised sound business judgment.

The only foolproof way for the practicing physician to guarantee that he or she will not be the victim of an embezzlement is to deliver health care without employees. The physician would have to greet patients, direct them to the examining room, collect fees for services rendered, send statements, make bank deposits, and so on. Naturally, this is not possible. To avoid this unproductive situation, physicians should take precautions to protect their hard-earned income.

The cash-flow situation in a physician's office is not unlike that of a bank. Large numbers of cash or check transactions, generally for small amounts, occur daily. These transactions involve many active accounts. There are embezzlement-protection techniques that banks use which a physician can apply in his/her office.

Mr. Walsdorf is a program director in the Department of Practice Management of the American Medical Association in Chicago.

Hire Carefully

There is no substitute for honest employees so the first protection is to have only the best people working for you. Giving the job to the first person who walks through the door may save you time right now, but it can cost you dearly "down the pike." Never hire an assistant until you are satisfied that he/she has an excellent chance to be a competent and honest employee.

Banks check meticulously the references of people they are considering as employees; you must do the same. Currently, it is estimated that less than 10% of all physician-employers are making even a quick check of references. This is sad, because the information gleaned during the reference check would help make a better hiring decision. Many would be quite surprised at some of this information. The fact is that a study of 4,000 embezzlements showed that 68% of the perpetrators were repeaters. Certainly, a number of embezzlements could have been prevented if the physician had taken the time to call the former employers of people he/she considered hiring.

Checking references will take only a few minutes. Before doing so, have written approval from the applicant to call current and former employers to ask a few questions. It is always best to talk to the individual's immediate supervisor rather than the personnel department. Telephone calls are usually more productive than written inquiries because more and better information can be exchanged quickly. Phones are also helpful because you are interested in the positive and negatives about your applicant, and people are often reluctant to express negative opinions about others in writing.

"Would you rehire so-and-so?" is a good beginning to the conversation. In addition, ask for such information as the main duties the applicant performed, his/her best attributes, and why the individual left the previous employment.

When you finally hire someone, compensate him/her adequately. Since real or imagined grievances on the part of medical assistants can lead to embezzlement, realistic salary levels are a preventive measure. For example, an employee may believe that he/she is entitled to the extra "income" because of being underpaid or not being promoted as rapidly as desired. Competitive wage rates will not totally solve the problem, but they can go a long way in relieving both hard feelings and sticky fingers.

Money-Handling Responsibility

Division of the money-handling responsibility is another key factor in the prevention of embezzlement. Because the overwhelming majority of medical assistants are honest, the probability of collusion among two or more of your employees is low. However, there is potential trouble when one person has total money-handling responsibility. That person can manipulate the system to his/her advantage. So, have one employee open the mail and post the receipts to the patient financial ledger card and day sheet. Have another employee make the bank deposit, post charges to patients, and send the statements.

Another place for division of responsibility involves paying bills for expenses incurred in the practice. One medical assistant was able to siphon over $4,000 to a "dummy" supplier that she created. The assistant would prepare the checks for the physician to sign; and as he was in the habit of signing checks without reviewing what the check was for or checking the accuracy of the invoice, each time the medical assistant needed extra money, the practice would receive another "bill" for supplies.

Another safeguard is for the physician to open all the incoming practice mail for one day every four to six weeks. After a few months, you should have an idea as to the amount of money received through the mail. You will also know the mix between cash and checks received. If there is a substantial difference between the day-sheet entries and what you know the average to be, start asking questions.

On a periodic basis, without your medical assistants' knowledge, keep a listing of the patients seen during a day. Use a 3x5-in. card to list the name of each patient, the service, and the fee. At the end of the day, compare the index card to the day sheet for accuracy. If there is an error, you must investigate. Use this procedure every month or two on a different day of the week.

An outside audit is another preventive measure that banks could not be without, and your medical office accounts should be audited yearly by an outside person. Your accountant should be able to perform the audit or recommend someone who can.

It is true that these preventive measures add to the overhead, but the money is well spent as the procedures discourage potential thieves.

Become Involved

The most important aspect of preventing embezzlement only requires that the physician take an active interest in the financial management of the practice. His/her attitude sets the tone for the entire office; if the physician is casual about money, the employees will be too. The physician who "borrows" from petty cash or from receipts is likely to have assistants who do the same.

The vast majority of medical assistants are honest. However, be careful when one employee: (1) has total responsibility for all money handling, (2) works long hours and refuses to take a vacation, (3) takes work home "just to catch up," and/or (4) refuses to delegate any part of the accounting function. In addition, question the financial management of the practice if there is no inside or outside audit.

Bonding

Even the most careful physician cannot devise a fail-safe system to prevent embezzlement totally. For this reason, it is important to safeguard practice assets with "honesty insurance," or what is known as a fidelity bond. This type of insurance is relatively inexpensive and can reimburse you for losses due to fraud or dishonesty. However, fidelity bond insurance will not reimburse you for losses due to an "honest" error arising from negligence or incompetence.

During the first discussion with the applicant, ask if he/she is willing to be bonded. Unwillingness should be enough warning for you.

The most common fidelity bond is one which will cover a physician's entire staff, regardless of the jobs they perform. This is known as the blanket bond. Other bonds are available to cover specific individuals by name or a specific position in the office. In the latter case, any person who holds that job will be covered.

Although most insurance companies sell fidelity bonds, some individual agents may not be very familiar with the offerings. We suggest that you consult with your attorney or accountant before you purchase protection.

The amount of protection you purchase depends on your philosophy. Some physicians will bond for only $2,000 to $3,000 for its deterrant value. Realistically, to protect your practice against actual losses, you should purchase a minimum of $20,000 coverage. However, a large group practice or corporation should insure for considerably more. The cost of bonding is relatively low, in some instances beginning at $50 per year for a one-employee practice with $10 per year for each additional employee. The cost of a blanket bond to cover actual losses is higher since it offers more protection.

Some physicians are reluctant to bond their employees, particularly those with many years of service. You can alleviate employee objections by pointing out that bonding is a good business practice. An honest assistant should not mind. An assistant who objects loudly and refuses to be bonded may be telling you something.

Remember, the ultimate responsibility of safeguarding the practice assets rests with you. You have nothing to lose— except your honest earnings.



PREPARE FOR YOUR:

National Medical Boards
(PART I, II, OR III)
ECFMG–VQE–FLEX
National Dental Boards
(PART I OR II)
Nursing Licensure Examination

- Voluminous home-study notes on areas covered on NMB-I & NDB-I & II.
- Sample questions accompanied by comprehensive teaching tapes to use at any of our tape centers.
- Materials constantly updated and revised.
- Study at your own pace via tape recordings at centers most convenient for you.
- Forty years of experience and success in the field of test preparation.
- When it comes to preparation, more students enroll in our courses because . . . THERE IS A DIFFERENCE!



Stanley H. KAPLAN
EDUCATIONAL CENTER
Test preparation specialists since 1938.

For more information or for other locations, call Toll Free: 800/223-1782.

CLEVELAND AREA:
14055 Cedar Road
Cleveland 44118 Phone: 216/371-0035

COLUMBUS AREA:
1890 Northwest Boulevard
Columbus 43212 Phone: 614/486-9646

CINCINNATI AREA:
309 Ludlow Avenue
Cincinnati 45220 Phone: 513/281-1818

Other Stanley H Kaplan locations in Albuquerque, Ann Arbor, Atlanta, Austin, Baltimore, Birmingham, Boston, Champaign, Charleston, Chicago, Cleveland, Columbus, Dallas, Denver, Detroit, Durham, East Brunswick, El Paso, Gainesville, Houston, Indianapolis, Kansas City, Los Angeles, Louisville, Lubbock, Madison, Memphis, Miami, Milwaukee, Nashville, New Haven, New Orleans, Oklahoma City, Omaha, Palo Alto, Philadelphia, Phoenix, Pittsburgh, River Falls, St Louis, Salt Lake City, San Antonio, San Diego, San Francisco, Seattle, Tampa, Washington D C Stanley H Kaplan locations abroad Lugano, Switzerland, San Juan, Puerto Rico, Toronto, Canada
Other planned locations Allentown, Little Rock, Minneapolis, Portland

© 1978 STANLEY H KAPLAN ALL RIGHTS RESERVED

THE OHIO STATE Medical Association Cancer Education Series*

Cervical Cancer Screening Program Using Papanicolaou's Stain Test

Aileen L. MacKenzie, M.D.
James F. Martin, M.D.

IN 1973, THE NATIONAL CANCER Institute (NCI) invited state and territorial health departments to participate in a "cervical cancer screening program." The main objective of this program is to lower the incidence and mortality from invasive cancer of the uterus among high-risk women, particularly those in the lower socioeconomic group, by cytologic examinations using the Papanicolaou's (Pap) stain test.

The status of cervical cancer in Ohio in 1973 was:

1. The Ohio mortality rate for cervical cancer was 6.1 per 100.000 female population, 5.8 for whites and 8.7 for nonwhites, total, 336 deaths. Eighty-two percent of the cervical cancer deaths occurred beyond age 44 years.

2. Fifteen of Ohio's rural counties were without cervical cancer detection clinic services for indigent women. Seventy-three counties had population control clinics, but their services were not available to women beyond childbearing age.

The program was endorsed by the Ohio State Medical Association and the Ohio Cancer Coordinating Committee, Inc. In June of 1974, the National Cancer Institute awarded a three-year contract to the Ohio Department of Health which has been implemented in the following manner.

Target Population.— Includes women who have never had a Pap test, those who cannot remember when they had a Pap test, and those who have not had a Pap test in the last 12 months. Special emphasis is placed on reaching low-income women and those beyond childbearing age.

Local Responsibility.— The local public health department sponsoring the Pap test clinics assumed the responsibility of obtaining the support of their medical community, administrative services, providing a clinic site, obtaining community support, informing the public, selecting the part-time clinic staff, ordering supplies, assisting with the operation of the clinic, providing outreach to locate the high-risk women, following up on all non-negative reports, and assisting with rehabilitative services. Several counties organized community advisory committees that have proved invaluable in solving local problems.

The American Cancer Society, Ohio Division, which offers strong support to the program, is represented on the State Advisory Committee and has made grants to the local cancer units to assist with items not funded by NCI, such as staff travel, phone, and mailing costs. Volunteers, professional and lay, and literature of the American Cancer Society have contributed significantly to the local clinics.

The following counties were selected on the basis of need and mortality rate for cervical cancer:

Adams	Delaware	Hocking	Portsmouth City
Ashland	Fayette	Lawrence	Putnam
Athens	Hancock	Licking	Seneca
Belmont	Hardin	Meigs	Vinton
Columbiana	Harrison	Perry	Wyandot

The Pap testing clinics offer at least two monthly clinics staffed by part-time personnel: a clinician (a physician in 17 counties and a registered nurse practitioner in three counties), a clinic nurse, an outreach worker, and a clerk. The news media in most counties carry clinic announcements. Most of the women are seen by appointment, however, walk-ins are accepted. Women are screened every 12 months; those with negative reports receive an annual clinic appointment reminder. Services provided in each clinic include a health history, height

Dr. MacKenzie, Columbus, Chief, Division of Chronic Diseases, Ohio Department of Health.
Dr. Martin, Huntsville, a primary care physician, is clinician for the Hardin County, Kenton, Cervical Cancer Screening Program; Health Commissioner for Hardin County; and Staff Member, Hardin County Memorial Hospital.
Submitted October 3, 1977.

The Journal is pleased to publish this series through the cooperation of the OSMA Committee on Cancer and the American Cancer Society, Ohio Division, Inc.

and weight check, instruction in self-breast examination, an explanation of the clinic procedures, blood pressure reading (sitting), and dip-stick urinalysis. The clinician performs a breast examination, visualizes the cervix, takes a Papanicolaou smear, performs a pelvic and rectal examination, and answers the patient's questions. Before the patient leaves, either the clinic nurse or another worker answers questions and explains the reporting system, ie, each woman screened receives a report and all positive findings from the examination are referred to the patient's physician. The clinic nurse assists the client in obtaining a personal physician if she does not have one.

Women with suspicious and positive cervical cytology reports are contacted by telephone or by a home visit from a public health nurse. The report is explained, and the woman is referred to her personal physician for diagnosis and treatment. The program pays for uterine diagnostic procedures when there is no third-party payer.

All of the Pap smears are processed and the results reported by the Pathology Department, Division of Clinical Cytology of the Ohio State University Hospital.

A report of each clinic visit and the cytology result are sent to the National Cancer Institute, Data Base System Agency.

Progress and Results.— The first of these clinics opened in October 1974, and all 20 of them were functioning by the end of 12 months. (Eleven percent of the first 6,500 of those screened received their first Pap test.)

The accumulated *Data Base* on July 30, 1977 includes:

1. Cervical cytology screening had been provided for 18,616 women; 62.5% were from the low-income population; 98.1% were white; 1.4% were black; and 0.3% were of Spanish origin.

2. "Negative cytology" was reported for 97.9% of those screened, 0.1% "unsatisfactory," 1.6% "inconclusive," 31, or 0.2%, received "suspicious" reports, and 25, or 0.1%, were reported "positive for cervical cancer."

Comments

Many women request an explanation of the details of the examination offered at the Pap screening clinics. There is the need to instill in these women the value of periodic, "health check-ups," including cytology testing, to their personal and physical well being. This especially includes sexually active women and those who have had a hysterectomy. The mortality rate for cancer of the breast in women is approximately six times the mortality rate for cancer of the cervix. When a Pap test is performed, it is an opportune time to examine the breasts and make recommendations for monthly self-breast examination.

IMMKE CIRCLE LEASING INC

Endorsed Leasing Company
Of The Ohio State Medical Association

Immediate delivery on many 1978 models

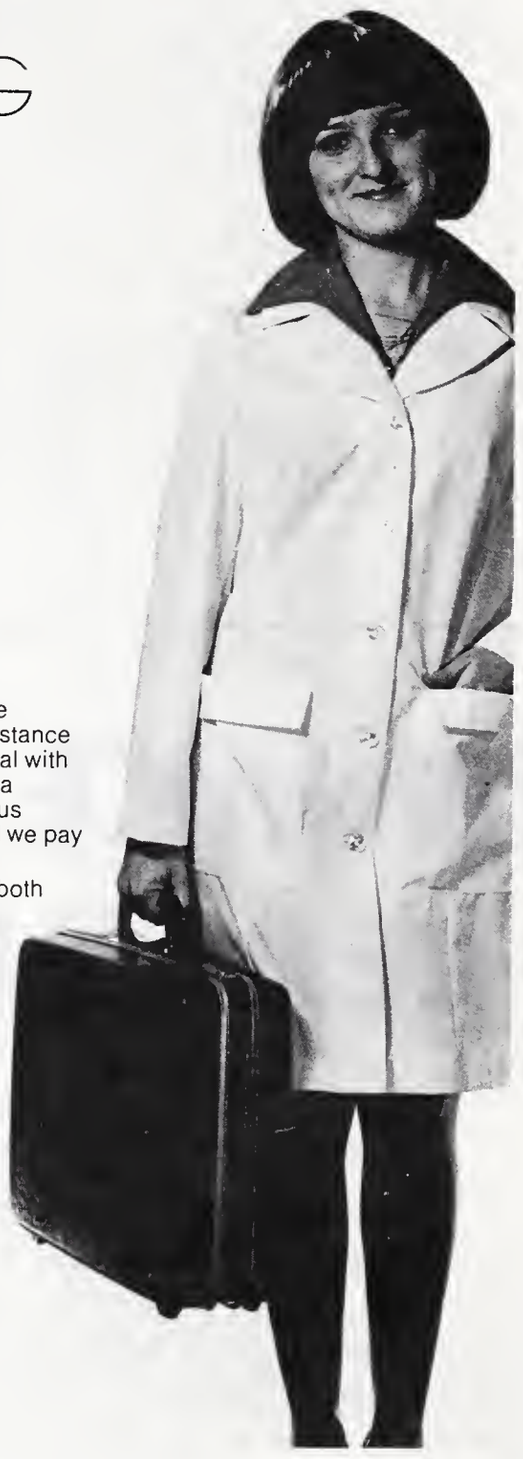
We lease all foreign and domestic makes and models
including Mercedes, Jaguar, Porsche, etc.

Many people think of leasing as just automobiles.
We do that too, but, in addition, we want to lease you any professional equipment.

Immke Circle Leasing, Inc.
32 South Fifth Street
Columbus, Ohio 43215

Telephone 614-228-1701 or Toll Free 1-800-282-0256

Your hospital's complete EEG laboratory!



Daneman Laboratories' space-age electronics technology and two long-distance telephone calls will provide your hospital with same-day EEG and ECHO readings by a qualified neurologist. Even instantaneous reports can be provided if needed. And we pay for the phone calls!

This service has wide benefits for both hospital and patient:

- Fully effective
- Safe and comfortable
- Professionally-administered
- Easily performed
- Inexpensive
- Fail-safe reporting procedures
- Already in operation nationwide

For a copy of our easy-to-understand, no-obligation proposal, please call or write Business Manager Jean Murphy.

Daneman Laboratories

P.O. Drawer 152, Gambier, OH 43022
Telephone 614-427-4577

OHIO STATE Medical Association New Members

ALLEN (Lima)
J. Robert Kuhns

ASHLAND (Ashland)
Mohinder Gupta

ATHENS (Athens)
Constantine H. Makris
Marjorie E. Nelson

CARROLL (Carrollton)
William S. Green

CLARK (Springfield)
Charles Attah

CUYAHOGA (Cleveland)
Priscilla I. Ancheta
Jessie C. Arjona
David R. Bickers
Lina A. Bigornia
Azmy Boutros
Ernesto C. Bunye
Gerard A. DeoReo, Jr.
Leonard A. R. Golding
Benjamin H. Grosky
Daniel Grum
Sau Q. Huang
Carl R. Kelly
John T. Lanning, Jr.
Ian C. Lavery
Subhash C. Mahajan
Andrew C. Novick
Albert L. Rabinovitch
Dinkar V. Rao
James E. Redford
Paul F. Retter
James Rintoul
Jose M. Rivera
Mansoorem Salari-Lak
Raymond L. Sattler
Lee Philip Schacter
Ronald J. Scott
Edward D. Sivak
Robert F. Spetzler
Hippocrates P. Tabora
Byung H. Woo

FAIRFIELD (Lancaster)
Leelawati B. Gogate

FRANKLIN (Columbus)
Leona B. W. Ayers
Robert W. Clark
R. Scott Heath
Kenneth R. Parker
Ronald C. Pinson
William B. Salt, II
Peter V. Scoles

GEAUGA (Chardon)
Cheerasak Arunthari
Ming-Hong Wu

HAMILTON (Cincinnati)
Alvin H. Crawford
David T. Gilliam
George D. J. Griffin, III
Clark N. Hopson
Donald G. Nunlist-Young
Thomas A. Tomsick
Mattie Lou Vaughn

HANCOCK (Finlay)
James Robertson

HURON (Norwalk)
Benjamin A. Grella, Jr.

LORAIN (Lorain)
John G. Secrist

LUCAS (Toledo)
Joseph Collaco
Josephine F. Collaco
Wilson G. Felix
George D. Jacobs
Bernardo Martinez
Gary J. McBride
Yoon M. Yim

MAHONING (Youngstown)
Vikram A. Raval
Tae Ryang Rhee

MARION (Marion)
William Keeler

MONTGOMERY (Dayton)
Florence Dobies
Alice F. Fisher
Andrew F. Forbat
Neil D. Martin
Warren F. Muth
Jane B. Schieve

PICKAWAY (Circleville)
E. Rodman Heine

STARK (Canton unless noted)
Farouq Ahmed
Iqbal A. Choudhry, North Canton
Paul S. Cohen
Jong S. Kim
Stephen A. Lohr
Indravaden P. Patel
Robert Spangler

TRUMBULL (Warren)
Jose Alappatt
Chun C. Chan
Siva P. Kurup
Yong H. Lee
Manthena A. Raju

WOOD (Bowling Green)
William Feeman, Jr.

THE OHIO STATE Medical Association Obituaries

HAROLD B. ELLIOTT, M.D., Springfield; Rush Medical College, Chicago, 1929; age 76; died April 10; member OSMA and AMA.

WILLIAM FEICKS, M.D., Lorain; University of Michigan Medical School, 1946; age 58; died April 3; member OSMA and AMA.

HOWARD D. GILES, M.D., Columbus; Ohio State University College of Medicine, 1927; age 79; died March 26; member OSMA and AMA.

JAMES G. HEALEY, M.D., Columbus; Ohio State University College of Medicine, 1939; age 66; died November 2, 1977; member OSMA and AMA.

CHARLES R. HUGHES, M.D., Cleveland; University of Pennsylvania School of Medicine, 1934; age 66; died March 17; member OSMA and AMA.

FRED KAUFFMANN, M.D., Brownsville, Texas; Medizinische Fakultat der Ludwig-Maximiliams-Universtat, Munchen, Bayern, Germany, 1923; age 81; died December 19, 1977; member OSMA and AMA.

WALTER E. KRAMER, M.D., Chillicothe; Ohio State University College of Medicine, 1938; age 70; died March 31; member OSMA and AMA.

HYMAN P. LEVIN, M.D., Cleveland; Medical College of Virginia, Health Sciences Division Virginia Commonwealth 1925; age 79; died March 28; member OSMA and AMA.

ELIZABETH T. LONG, M.D., Fort Lauderdale, Florida; Ohio State University College of Medicine, 1928; age 72; died March 13; member OSMA and AMA.

TREAT THE SYMPTOMS IN THE GERIATRIC PATIENT

APATHY • IRRITABILITY
FORGETFULNESS • CONFUSION



Cerebro-Nicin® CAPSULES

A GENTLE CEREBRAL STIMULANT & VASODILATOR FOR GERIATRIC PATIENTS

Each CEREBRO-NICIN capsule contains:
Pentylenetetrazole .....100 mg. • Nicotinic Acid ...100 mg.
Ascorbic Acid .....100 mg. • Thiamine HCl .....25 mg.
l-Glutamic Acid .....50 mg. • Niacinamide .....5 mg.
Riboflavin .....2 mg. • Pyridoxine HCl .....3 mg.
AVAILABLE: Bottles 1DD, 5DD, 10DD
SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and abdominal cramps. The reaction is usually transient.
INDICATIONS: As a cerebral stimulant and vasodilator.
RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.
WARNING: Overdosage may cause muscle tremor and convulsions.
CONTRAINDICATIONS: Epilepsy or low convulsive threshold.
CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

Write for literature and samples . . .
BROWN THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057

JAMES A. McNALLEY, M.D., Sun City, Arizona; University of Kansas School of Medicine, Kansas City, 1932; age 81; died February 16; member OSMA and AMA.

JOHN W. MOSES, M.D., Akron; Boston University School of Medicine, Boston, 1946; age 56; died April 13; member OSMA and AMA.

MAX MILLER, M.D., Cleveland; Yale University School of Medicine, New Haven, 1935; age 67; died March 25; member OSMA.

HOWARD H. MINOR, M.D., Steubenville; University of Pennsylvania School of Medicine, 1931; age 71; died March 21; member OSMA and AMA.

WILLIAM V. PARENT, M.D., Lima; Ohio State University College of Medicine, 1918; age 84; died March 20; member OSMA and AMA.

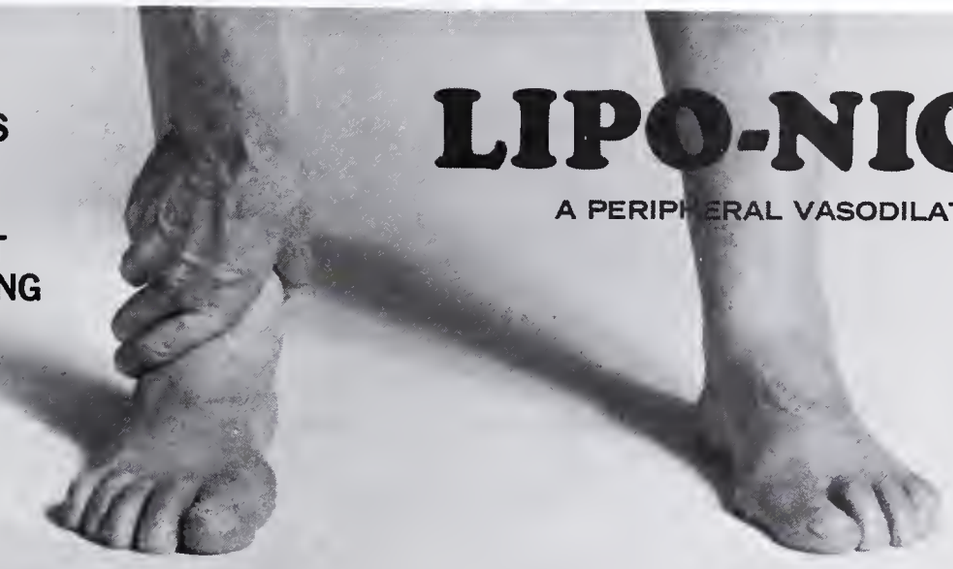
THEODORE TAKACY, M.D., Leesburg; Western Reserve University Medical School, 1938; age 66; died March 22; member OSMA and AMA.

JOHN A. WHIELDON, M.D., Worthington; Loma Linda University School of Medicine, Loma Linda, 1942; age 63; died April 17; member OSMA and AMA.

Journal Advertisers

AmeriCare Emergency Services 384
Breon Laboratories, Inc. 389, 390
Brown Pharmaceutical Company, Inc.....416, 417, 422
Burroughs Wellcome Co. 351, 393
Daneman Laboratories.....414
Eli Lilly and Company.....374
Harding Hospital.....367
Immke Circle Leasing.....413
INTRAV 362
Mead Johnson.....407, 408
Medical Protective Company..359
Menendian Carpets.....399
Nationwide Professional Services Corp.....361
Ohio Medical Indemnity.....388
Pennwalt Prescription Products 368, 369
Pharmaceutical Manufacturers Association.....352, 353
Physicians Insurance Company of Ohio, Inc.....379
PICO Life.....421
Practice Productivity.....394
Roche Laboratories, Div. of Hoffmann-LaRoche, Inc. ....347, 348, Cover 2, Cover 3, Cover 4
Smith Kline and French Labs 372, 373
St. Anthony Hospital.....403
Stanley H. Kaplan Educational Center.....411
Turner and Shepard, Inc.....357
United States Air Force.....420
United States Navy.....424
Upjohn Pharmaceutical Company.....380
Warren-Teed Laboratories 365 397
Wendt-Bristol Company...359, 418
Windsor Hospital.....405

COLD FEET
LEG CRAMPS
TINNITUS
DISCOMFORT ON STANDING



LIPO-NICIN
A PERIPHERAL VASODILATOR

IMMEDIATE or GRADUAL
nicotinic acid therapy

IMMEDIATE RELEASE

LIPO-NICIN/100 mg.
Each blue tablet contains:
Nicotinic Acid .....100 mg.
Niacinamide ..... 75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .. 25 mg.
Riboflevin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6).. 10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500, 1000.

LIPO-NICIN/250 mg.
Each yellow tablet contains:
Nicotinic Acid .....250 mg.
Niacinamide ..... 75 mg.
Ascorbic Acid .....150 mg.
Thiemine HCL (B-1) .. 25 mg.
Riboflavin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6).. 10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500, 1000.

GRADUAL RELEASE

LIPO-NICIN/300 mg.
Each time-release capsule contains:
Nicotinic Acid .....300 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (H-1) .. 25 mg.
Riboflavin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6).. 10 mg.
In a special base of prolonged therapeutic effect.
DOSE: 1 to 3 teblets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vesodiletor in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient. Side Effects: Transient flushing and feeling of wermth seldom require discontinuation of the drug. Transient headeche, itching and tingling, skin rash, allergies and gastric disturbance may occur. Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diebetes, impaired liver function, peptic ulcers, end arterial bleeding.

BROWN THE BROWN PHARMACEUTICAL CO., INC. 2500 West Sixth Street, Los Angeles, California 90057
Write for Literature and Samples
REFER TO PDR

We create impressions...

Impressions for physicians who are concerned about their patients' peace of mind. We design professional environments with a personal touch. If you would like to make an impression, contact us. We're Medical Interiors, a division of the Wendt-Bristol Company.



medical interiors

a division of
THE WENDT-BRISTOL CO.
1107 dublin road p.o. box 144
columbus, ohio 43216

AMERICAN SURGICAL TRADE ASSOCIATION A.S.T.A.

☐ please send a brochure explaining your design concepts.
☐ I'm interested in learning more about MEDICAL INTERIORS.

the wendt-bristol company

NAME

ADDRESS

CITY STATE ZIP

OSMJ-6/78

The Ohio State Medical Association News

Florida Medical Assoc. Sues HEW

The Florida Medical Association has filed suit against the Department of Health, Education, and Welfare (HEW) and its Secretary, Joseph A. Califano. The Association seeks to permanently enjoin the Department and its contractors, Blue Shield of Florida, Inc. and Group Health Insurance, Inc. of Miami, from releasing and disclosing publically information related to Medicare payments made directly to physicians or to their patients.

The FMA suit alleges that the proposed disclosure by HEW of this information is not compatible with the purposes for which it was collected; will constitute an abuse of discretion under the laws, regulations, and policies of the United States; and will be in violation of the Privacy Act of 1974, which regulates the release of this kind of information. Additionally, the suit contends that this information will be disseminated without HEW having made any reasonable efforts to insure that such information is accurate and complete.

Moreover, the suit states that the information is confidential financial and medical information which relates to the private and personal financial or medical matters and affairs of both the physicians and their patients. Lastly, the suit contends that the disclosure of this information by HEW, without the consent of the physicians and their patients, would constitute an unwarranted invasion and violation of the rights of privacy of both physicians and their patients as such rights are protected by the United States Constitution and the 1st, 4th, 5th and 14th Amendments.

Referring to the release of Medicare payment lists by HEW, Louis C. Murray, M.D., Orlando, FMA President, stated: "This is a further attempt by the federal government to invade patient privacy, intimidate an honorable medical profession, waste a tremendous amount of money, and contribute further to the cost of medical care provided by the government."

Administration Sends Congress Bill to Overhaul Drug Laws

The Carter Administration has sent Congress a bill to overhaul prescription drug laws. Three other measures calling for significant changes are already before the Congress. The Administration's bill would:

- Establish a monograph system for drug approval. The monograph would apply to the generic form and subsequent manufacturers would need only to confirm that their drugs meet established criteria. The original manufacturer would be given a five-year lead time during which competitors could not bring "me too" products on the market.
- Give the Secretary of Health, Education, and Welfare extensive controls over the distribution and dispensing of drugs. The Secretary could limit the distribution of a new drug to physicians with specific training or experience and to certain facilities as well as could require post-marketing surveillance for all drugs.
- Require patient-information labeling for most drugs, including side-effects and adverse reactions; posting of prices in pharmacies; and publication of a federal drug compendium.

Currently, the AMA is developing amendments to the present law that would speed up the introduction of safe and effective drugs, provide an optional procedure for the new drug-approval process, and provide for patient-information leaflets under certain conditions.

New PICO Rate Classification

The Physicians Insurance Company of Ohio (PICO) has announced a change in rate classification. Physicians who perform needle biopsies, previously rated Class II, now are included in the Class I designation. President Joseph K. Gilmore noted that the change primarily will benefit internists who perform liver biopsies. The new classification became effective April 18, 1978 for new policies written and on the respective renewal dates of policies in effect.

AMA Tries to Remove FMG Board-Certification Requirement

The AMA will seek deletion of the board-certification requirement for foreign medical graduates (FMGs). Present law permits FMGs who were in the United States on January 9, 1977, who are licensed by a state and certified by a specialty board, to continue their visas without taking further examination. The AMA Council on Legislation said many FMGs have not been practicing medicine long enough to meet board requirements. It also said the use of a voluntary standard as a mandatory immigration requirement is inappropriate. The AMA Ad Hoc Committee on Foreign Medical Graduate Affairs has recommended that the AMA seek to amend the law.

Nursing Graduate Education Funds

The Ohio Department of Health, Division of Maternal and Child Health, has announced that funds are available to assist nurses who wish to pursue graduate study in maternal and child health nursing beginning summer and/or fall 1978. For further information, contact Mrs. Kathy Peppe, R.N., Ohio Department of Health, Division of Maternal and Child Health, P.O. Box 118, Columbus, Ohio 43216.

Physicians. Isn't It Time Your Career Had A Check-Up?



Of course, we don't mean that your career isn't a healthy one. We just want to draw your attention to the career opportunities and benefits the Air Force can offer. You'll discover that the Air Force is a challenging and rewarding way of life. Our hospitals and clinics are outstanding. Plus, we'll pay relocation expenses for your family and household goods when you move. If you're interested in our medical career plan, find out all the facts. Sometimes, even a healthy career could use a check-up.

USAF MEDICAL RECRUITING

Post Office & Court House Bldg.
Rm. 301, Government Square
Cincinnati, Ohio 45202
Phone: 513/381-4141

16101 Snow Rd.
Suite 300
Cleveland, Ohio 44142
Phone: 216/522-4325

Air Force. A great way of life.

Picolife

YOUR NEW SOURCE FOR

- **Life Insurance**
- **Annuities**
- **Retirement Plans**

Pico Life Insurance Company, a newly-formed subsidiary of Physicians Insurance Company of Ohio (PICO) is offering life insurance, retirement plans and annuities to members of O.S.M.A.

Pico Life emphasizes the professional insurance concepts you've come to expect from the PICO organization: comprehensive coverages, competitive rates, superb services, and insurance plans tailored to meet the specific needs of physicians and surgeons.

You'll soon be receiving detailed information about our products. We hope you'll become one of our first policyholders.

Many fine companies would like to sell you life insurance, retirement plans and annuities. But only one was formed by OSMA physicians and is owned by OSMA physicians, to serve OSMA physicians.

That's Pico Life.

Picolife

Pico Life Insurance Company
6100 Channingway Boulevard
Columbus, Ohio 43227
Telephone 614-864-0280

A Subsidiary of Physicians Insurance Company of Ohio

When **impotence** due to androgenic deficiency is driving them apart





Android®-5 Buccal Tabs
Android®-10 Oral Tabs
Android®-25 Oral Tabs

Methyltestosterone U.S.P. – 5, 10, 25 mg.

Additional Indications:
REPLACEMENT THERAPY. When Androgen Deficiency is cause of:

- Male Climacteric
- Eunuchoidism, Eunuchism
- Post-Puberal Cryptorchidism

New Double-Blind Study ANDROID-25 vs. Placebo*

*R. B. Greenblatt, M.D.; R. Witherington, M.D.,; I. B. Sipahioglu, M.D.; Hormones for Improved Sexuality in the Male and Female Climacteric. **Drug Therapy**, Sept. 1976.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE: Robert B. Greenblatt, M.D.,** and **D. H. Perez, M.D.:** "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

BROWN **THE BROWN PHARMACEUTICAL CO., INC.** 2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

Write for Reprints and Samples.

Classified Ads

Rates: $3 per line. Display classified: $5 per line. Minimum 3 lines per insertion. Ads measure 8 lines to the inch. Box number reply: Flat $5 charge in addition to line cost for up to and including three insertions. (Covers cost of mailing replies which are kept confidential.) Forms close the 10th day of the month preceding month of publication. Address all ads Attention: Classified Ad Department, ***The Journal.***

To assure prompt delivery, when replying to an advertisement over a ***Journal*** box number, address letters as follows: Box (insert number), c/o ***The Ohio State Medical Journal,*** 600 South High Street, Columbus, Ohio 43215.

SURGICAL ASSISTANT: Recent graduate of Case Western Reserve University's Surgical Assistant Program, B.S. in health science (surgery), is interested in locating a surgeon (or a rural community hospital) looking for a surgical assistant to work in his medical-surgical practice. Curriculum vitae will be sent on request. Send all inquiries to: R. Scott Anderson, 190 Brockdorf Dr., Wyoming, Ohio 45215, phone: 513/761-6877.

(EDITOR'S NOTE: *The Journal* presents the above classified advertisement to its readers as an announcement of the physician's assistant and assumes no responsibility for the statements made.)

SURGICAL HOUSE PHYSICIANS: Full training required. Excellent salary and fringe benefits, 48-hour week. Contact: J. Lopez, M.D., Director, Department of Surgery, St. Alexis Hospital, 5163 Broadway, Cleveland, Ohio 44127, phone 216/641-3300.

PEDIATRICIAN WANTED: For 45-man multispecialty group located in prosperous central Ohio community. Present department includes four pediatricians providing 37,000 outpatient visits yearly. Attractive salary and unusual fringes, including retirement program; early partnership with minimum financial investment. Send C.V. or call collect to Albert May, M.D. or Bruce Dyer, Executive Director—614/382-8251.

FAMILY PRACTICE PHYSICIANS: One or two. Excellent opportunity for private practice. Medical arts building available for lease or sale. Well-equipped, modern, three examination rooms. Parking space. Ten minutes to hospitals. Population of community including rural radius 4,000 to 5,000 persons. Low malpractice rates. Easily accessible to three major cities. Contact Mr. or Mrs. S. Roger Blackburn, Pharmacists, New Vienna Pharmacy, P.O. Box 194, New Vienna, Ohio 45159, phone: 513/987-2212.

AVAILABLE: Long-established physician's office for rental or property purchase. Excellent practice opportunity for general practitioner. Reply to: 329 Vassar Avenue, Elyria, Ohio 44035.

EMERGENCY DEPARTMENT PHYSICIAN: One full-time or two part-time. Competitive pay scale; 2 wks. paid vacation; 2 wks. educational leave. Good backup. Pleasant, northeast Ohio, growing, rural hospital; 15,000 emergency patients per year. May join Emergency Dept. corporation after 1 yr. Contact Dr. Pearce or Mr. Jacobs, Administrator, at 216/286-6131. Geauga Community Hospital, 13207 Ravenna Road (Rt. 44), Chardon, Ohio 44024.

DIRECTOR
CLINICAL LABORATORIES
The Jewish Hospital
of Cincinnati

We are seeking an individual to direct all professional and administrative activities of the entire Clinical Laboratory complex of this 637-bed, service-oriented, major affiliate of the University of Cincinnati Medical Center. Demonstrated administrative experience and board certification in Anatomical or Clinical Pathology is required.

Interested and qualified applicants should forward resume in confidence to Mr. Michael T. Coler, Vice President-Administration, The Jewish Hospital, 3200 Burnet Avenue, Cincinnati, Ohio 45229.

—An Equal Opportunity Employer—

PSYCHIATRY STAFF OPENING: Board-eligible or board-certified Psychiatrist in a reorganized service of outpatient-inpatient programs with 479 operating psychiatric beds and 40,000 outpatient visits. The environment is healthy; work standards high. An unusual opportunity for personal development and individual contributions to organizational upgrading. USCSC fringe benefits. Nondiscriminating in employment. Send application and resume to Chief of Staff, Paul F. Fletcher, M.D., VA Hospital, Chillicothe, Ohio 45601; Telephone 614-773-1141.

(Classified Ads continued on page 424)

FOR SALE: Physician's office, fully equipped. An established practice. Living quarters or apartment completely furnished upstairs. If interested, call 216/434-8923. Akron, Ohio.

OPHTHALMOLOGIST: Full-time position with multi-specialty group practice in southwestern Ohio very close to large metropolitan areas but with the advantages of family life in small city. First-year guarantee and excellent fringe benefit package with this incorporated professional group oriented to primary care. Conveniently accessible to continuing educational opportunities and university affiliation. Please reply to Box 829, c/o Ohio State Medical Journal.

PEDIATRICIAN: For Children and Youth Project. To provide ambulatory care in neighborhood health centers. Forty-hour week, no evenings or weekends. Must be board certified or eligible. Ohio license required. Send resume to E. Leahy, M.D., C & Y Project, Montgomery County Health District, 451 W. Third Street, Dayton, Ohio 45422 or call collect 513/225-4964.

CAPE COD: Falmouth, Maine. Good investment. Remodeled farmhouse. Two apartments. Former doctors' offices. Contact: Harold Bach, R.E., 617/540-0707.

PULMONARY PHYSICIAN: An established three-man practice in pulmonary medicine seeks a fourth associate with interests in respiratory therapy, pulmonary function, fiberoptic bronchoscopy, pulmonary rehabilitation, intensive care, and medical school teaching. Excellent opportunity, superb salary, youthful group in western suburbs of Cleveland. Excellent family environment. Call collect 216/226-6666 or reply with CV to Pulmonary Medicine Associates, Inc., 14601 Detroit Avenue, Lakewood, Ohio 44107.

GENERAL MEDICAL OFFICES AVAILABLE FOR RENT: In Hartville, reportedly the fastest growing township in Ohio. New construction permitting individual furnishing. Physically attached to Cancer Center with diagnostic x-ray, laboratory, and pharmacy facilities. Contact George N. Swallon Agency, Canton, Ohio, 216/456-3495, or inquire of R. K. Loeffler, M.D., 650 South Prospect, Hartville, Ohio 44632.

ORTHOPEDIST WANTED: By well-established, 41-physician, multi-specialty group in Ohio. Major regional medical center including four rheumatologists. Should be board certified or eligible. Please enclose current curriculum vitae with reply to Box 824 c/o Ohio State Medical Journal.

AMBULATORY CARE CENTER — EMERGENCY DEPARTMENT STAFF PHYSICIAN, ATHENS, OHIO: 20,000 annual patient visits. Flexible scheduling, minimum guarantee/monthly bonus, excellent fringes. Contact Eric Jenison, M.D., O'Bleness Memorial Hospital, Athens, Ohio 45701, or call toll-free 800/325-3982 for details.

FAMILY PRACTICE — RURAL PRACTICE: Northwest/central rural/agrarian community of 1200/1500 needs family practice physician. Practice could expand to cover 3000/3500 population area. No physician now practicing. Community will support. Major regional hospital within driving distance. Contact ROBERT FLINT, MARION GENERAL HOSPITAL, MARION, OHIO 43302, phone 614/382-8211 or 382-3442.

PSYCHIATRIC PRIVATE PRACTICE: Dayton, Ohio grossing $70,000+ in excellent downtown location. Wish to combine four-year-old suburban home in excellent neighborhood in one package sale. Phone or write: Walter J. Hill, M.D., Suite 760, Fidelity Bldg., Dayton, Ohio 45402, phone: office— 513/224-3929, residence— 513/434-9998.

MARION, OHIO: Excellent opportunities in Central Ohio. Existing and new, solo, partnerships, or association practices available and seeking physician support. Top compensation— reliable cross coverage. Exceptionally attractive, 250-bed, well-equipped regional medical center hospital within walking distance from offices. Industry and agriculture support city/45,000; county/65,000; and total trade area/250,000. Excellent schools and residential areas. Fifty-minute, easy drive to Columbus. Active need for—

FAMILY PRACTICE
INTERNAL MEDICINE
OTOLARYNGOLOGY
PEDIATRICS
ORTHOPEDIC SURGERY
EMERGENCY MEDICINE
GENERAL SURGERY

We are seeking either rural or city-oriented physicians. Send C.V. or contact— ROBERT FLINT, Marion General Hospital, MARION, OHIO 43302 — or call 614/382-8211 or 382-3442 any time.

FOR SALE OR LEASE: Large doctor's office, 5,000 sq. ft. X-ray equipment. 328 E. State Street, Columbus, Ohio, near Grant Hospital. Phone: 614/258-5644.

OB/GYN: Incorporated obstetrics/gynecology group seeking an additional member. Suburb of medium-size city, midwestern Ohio. Please send curriculum vitae and request for additional information to Box 825 c/o Ohio State Medical Journal.

RADIOLOGIST

Seventy-bed, not-for-profit community hospital in North Central Ohio is currently seeking a Staff Radiologist, effective immediately. Excellent growth potential in a department now at 15,500 procedures annually and with new Nuclear Medicine equipment. Superior position for associate or junior member of an existing corporation to have your own radiology department. Must be board certified or eligible in general Radiology and Nuclear Medicine. Send current, detailed curriculum vitate to Box 824, c/o Ohio State Medical Journal.

PHYSICIAN'S ASSISTANT: Certified 1976, seeking employment Reply: 216/351-6511.
(EDITOR'S NOTE: The Journal presents the above classified advertisement to its readers as an announcement of the physician's assistant and assumes no responsibility for the statements made.)

When was the last time your practice gave you a good night's sleep?

We're not talking about sleep that comes from sheer exhaustion.

We're talking about the kind of sleep that comes from knowing you practiced medicine today the way it was meant to be practiced. Of giving your patients the very best in medical care. With no compromises.

And a sleep that comes from knowing you won't be spending all of tomorrow morning filling out Medicare insurance forms, or attending to a myriad of other time-consuming, nonmedical duties.

But there is a practice that offers an alternative to the kind of medicine you're now practicing. A practice in the U.S. Navy.

The Navy physician.

As a Navy physician, we feel your time is too valuable to spend on administrative details. So they're kept to a minimum. Instead, a highly trained staff of professionals attends to the paperwork. The end result is that almost all your time can be spent practicing medicine.

A challenging practice.

You'll be given a practice that's as varied and challenging as any you'll find in a civilian setting. You'll be treating active duty personnel as well as their dependents and retired personnel.

Insurance.

A recent Act of Congress now makes it unnecessary for federally employed physicians to carry high cost insurance. As a practicing Navy physician, you will receive professional liability protection under the Federal Tort Claims Act.

Other benefits.

There are plenty of other great benefits that go with being a Navy physician. Good pay— $30,000 to start, more, depending on your experience. A family life with time for your family. Associating with other highly motivated physicians. Even 30 days' paid vacation a year.

But the best way to get all the facts is to mail the coupon, or call the Medical Recruiter, toll-free, 1-800-282-1288.

Be the doctor you want to be. In the Navy.

A1 1748

344260

JULY 1978
Volume 74 Number 7

THE OHIO STATE Medical Journal



LIBRARY
U.C. SAN FRANCISCO
JUL 20 1978

PUBLISHED BY THE OHIO S

THE LIBRARY
ACOUSTICS DIVISION
UNIVERSITY OF CALIFORNIA, SAN FRAN.
SAN FRANCISCO, CALIFORNIA 94143

PERFORMANCE. PROVEN EFFECTIVENESS WITHIN A WIDE SAFETY MARGIN.



While Roche Laboratories already knows more about the performance of Librium than anyone else, we keep on learning every day.

For example, the highly favorable benefits-to-risk ratio of Librium is a well-documented matter of record.

And, of course, the specific calming action of Librium has been demonstrated in millions of patients around the world. In a large number of these patients, Librium was used concomitantly with other primary medications.

Proven performance within a wide safety margin. Basically, that's what Librium is all about.

LIBRIUM® IV

chlordiazepoxide HCl/Roche

THE ANXIETY-SPECIFIC

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

ROCHE

Roche Products Inc.
Manati, Puerto Rico 00701

Legislative Update

the state scene

(Courtesy the OSMA Department of State Legislation)

Anesthesia Assistant Bill Fails

On June 22, 1978, the House failed to pass SB 130 (Jackson, D-Cleveland) when it was brought to the floor for a second time. (The bill was considered last March, but failed at that time too.) Many House members find the bill very controversial because it would permit anesthesia assistants (non-MDs) to administer anesthesia. Although some physicians oppose passage of this legislation, the Ohio Society of Anesthesiologists supports the bill.

House Judiciary Committee Limits Review of Medical Records

The House Judiciary Committee adopted an amendment to HB 1244 (Jaskulski, D-Garfield Heights) to limit the review of medical records during investigations by the Joint Mental Health and Mental Retardation Advisory and Review Commission.

Rep. Richard Finan (R-Cincinnati) attacked a proposed compromise that would have permitted unlimited access for medical records review to other than "licensed health care professionals." He was able to convince the Committee that review of medical records should be limited, and the Committee concurred in the proposal. The OSMA thanks Rep. Finan and the members of the House Judiciary Committee for maintaining the privacy of the records of patients in state mental hospitals.

Emergency Medical Bills Approved

During the June session of the General Assembly, the Senate approved and sent to the Governor HB 1092 (Branstool, D-Utica) permitting emergency medical technicians-ambulance (EMT-As) to maintain "intravenous lifelines." The bill was a result of a December Attorney General's opinion that limited EMT-As' ability to administer IVs.

Rep. Branstool brought together the OSMA and others representing fire and emergency squads to resolve the problem while ensuring proper training and medical direction.

A second emergency medical service bill was sent to the Governor's office when both chambers accepted the Conference Committee Report on SB 347 (Nabakowski, D-Lorain). This legislation grants civil immunity to EMT-As, EMT-Paramedics, emergency vehicle operators, or emergency medical personnel in training unless the administration of the treatment or operation of an ambulance constitutes willful or wanton misconduct. Rep. Branstool and Sen. Nabakowski should be commended for their cooperation during the passage of both bills.

Certificate of Need

House Finance Subcommittee deliberations on SB 349, the Certificate of Need (CON) bill continue although no action was taken during the recent two-week session. Rep. Larry Christman (D-Englewood), Chairman of the Subcommittee, has met recently with the OSMA Department of State Legislation to discuss the concerns of the OSMA, with particular reference to the inclusion of physicians' offices in the CON process and the $100,000 threshold for CON review. Another working session is planned in the coming weeks.

The Ohio Department of Health has already complied with the federal mandate for certificate-of-need review by adopting their recently promulgated Certificate of Need regulations. However, the General Assembly continues to be active in promoting their CON proposal.

Last week, the Ohio Senate approved an amendment that gives the Ohio Attorney General authority to enforce the Certificate of Need Regulations adopted by the Ohio Department of Health. The amendment gives the Attorney General the power to obtain an injunction against any health provider who makes a capital expenditure without obtaining a CON. The amendment is intended to insure that sufficient sanctions exist to enforce the Department of Health Regulations.

Bill to Permit Optometrists to Administer Dangerous Drugs Remains in House Judiciary

SB 163, the bill to permit optometrists to administer dangerous drugs remains in the House Judiciary Committee. During the past few months, representatives from the OSMA, the Ohio Ophthalmological Society, and the Ohio Optometric Association have been meeting together to discuss the provisions of SB 163 and the propriety of optometrists administering drugs without adequate training.

The three groups submitted written reports on these discussions to Judiciary Committee Chairman Harry Lehman before the start of the June legislative session. Although the bill can be reconsidered at any time, it was not brought up for reconsideration during the recent session.

The OSMA appreciates greatly the efforts of William Havener, M.D., Columbus, Chairman of the Department of Ophthalmology at The Ohio State University, who served as the OSMA representative to the negotiation sessions. Dr. Havener's input was and continues to be very helpful to the OSMA Department of State Legislation and the members of the House Judiciary Committee.



the federal scene

(Courtesy the AMA Washington Office and OSMA Department of Federal Legislation)

Comprehensive National Health Insurance Could Stretch Country's Finances

The Chairman of President Carter's Council on Economic Advisors (CEA) has told him that it is "unrealistic at this time to propose a national health insurance (NHI) package which mandates universal and comprehensive low-dollar coverage."

In a paper on NHI prepared for Presidential review, Charles Schultze said comprehensive coverage would "stretch thin" the health sector resources and thus exacerbate inflation. He indicated also that a sweeping NHI program would tend to "override completely" consumer latitude in choosing between health care and other goods and services such as housing and education.

The paper said the CEA believes the Administration's NHI plan should include better and "more rational" health assistance for the poor, and catastrophic coverage for lower- and middle-class families. These objectives should be financed out of general revenues, the CEA said, but without public reinsurance of private catastrophic programs except, perhaps, for health maintenance organizations. Otherwise, any mandated increase in private coverage— "presumably financed by premiums"— should be considered in terms of a minimal target package stripped of preventive care," the paper added.

The CEA paper also insists on stronger cost controls through regulatory legislation, but apart from any expensive health care package. "If the politics of the situation make it possible to combine a comprehensive benefit package with strong cost control, they should also make it possible to get the same cost control without the comprehensive package . . . insurance companies and individuals, who are the beneficiaries of a larger package, are not the ones who object to cost control," the paper concluded.

A "middle-of-the-road" national health insurance bill with powerful Senate backing has been introduced into the Congress. Emphasis in the bill is placed on catastrophic coverage. The measure is supported by Chairman Russell Long (D-La.) of the Senate Finance Committee, Health Sub-committee Chairman Herman Talmadge (D-Ga.), and Senators Abraham Ribicoff (D-Conn.) and Robert Dole (R-Kan.). The bill is substantially the same as the one introduced in the 94th Congress by Long.

"Our purpose . . . is to have before the Congress and the American people a legitimate national health insurance approach developed by the Congress," Long told the Senate. "This is not the Administration's proposal, nor that of any special interest group. It is our legislation."

Enactment of a NHI program with first-rate mental health benefits may be the best, single step to help mentally ill Americans, according to the report of the President's Commission on Mental Health. Declaring that one out of every seven suffers from some mental affliction, the Commission reported that too many are untreated. Almost half of the population could be classed as mentally ill or as experiencing severe emotional problems, the report said.

Headed by Thomas Bryant, M.D., the Commission was formed more than a year ago as a response to the keen interest in mental health by Mrs. Rosalyn Carter and Special White House Health Assistant, Peter Bourne, M.D., a psychiatrist.

"We firmly believe that a national health insurance program which includes appropriate coverage for mental health care offers the most effective means of providing adequate financing for . . . all Americans," the 20-member panel reported.

In an unprecedented joint effort, Senator Edward Kennedy (D-Mass.) and the AMA will sponsor a 2½-day conference on "Positive Health Strategies" in Washington, D.C., July 25-27. The sponsors have announced plans to bring together interested groups as cosponsors and participants to focus public attention on the potential benefits of strategies of disease prevention and to project possible programs for improvement in the 1980s.

Meanwhile, Sen. Kennedy has launched a major new health initiative with introduction of legislation to instruct Americans on good health practices and disease prevention. The bill calls for spending of $150 million the first year climbing to $300 million.

National health insurance can improve access to care, but it can't "make us a healthier and more long-lived people unless it is combined with a comprehensive strategy for reducing death and disability through prevention," Kennedy told the Senate.

Lowell Steen, M.D., a member of the AMA Board of Trustees, said the AMA is "basically supportive" of the measure, formally called the National Disease Prevention and Health Promotion Act of 1978. Dr. Steen told a national television audience that some of the programs are "things that the AMA has been advocating for many years." However, we have "some reservations" about certain provisions, Dr. Steen said.

Sen. Kennedy, appearing on the same program, said "I think we've got a good partnership," noting the jointly sponsored conference with the AMA in late July.

OSMA OFFICERS
President
JOHN J. GAUGHAN, M.D.
7911 Detroit Avenue
Cleveland 44102
President-Elect
THOMAS W. MORGAN, M.D.
P.O. Box 344
Gallipolis 45631
Past President
WILLIAM M. WELLS, M.D.
241 Hudson Avenue
Newark 43055
Secretary-Treasurer
ROBERT G. THOMAS, M.D.
630 East River Street
Elyria 44035

EDITORIAL STAFF
Consulting Medical Editor
RICHARD L. MEILING, M.D.
Managing Editor and Business Mgr.
HART F. PAGE
Executive Editor and Executive Business Manager
LINDA A. PORTERFIELD
Editorial Assistant
MARY LOU BRADY
Communications Editor
REBECCA J. DOLL
Continuing Medical Education Editor
GAIL E. DODSON
Ass't. Continuing Medical Education Editor
DAVID C. TORRENS
Federal Legislation Editor
CHARLES W. EDGAR
Field Service Editor
ROBERT E. HOLCOMB
Government Relations Editor
HERBERT E. GILLEN
Health Education Editor
ROBERT D. CLINGER
Membership Editor
KATHERINE E. WISSE
Organization Services Editor
JERRY J. CAMPBELL
State Legislation Editor
D. BRENT MULGREW, ESQ.
Ass't. State Legislation Editor
RICHARD A. AYISH

Address All Correspondence, Address Change, & Reprint Request (unless otherwise noted):
Executive Editor
The Ohio State Medical Journal
600 South High Street
Columbus, Ohio 43215
Phone: 614/228-6971

Published monthly under the direction of The Council for and by members of The Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215, a scientific society, nonprofit organization, with a definite membership for scientific and educational purposes.

1978 Subscription: $10 per year, single copy $1.50 (outside U.S. $13 and $2).

Entered as second class matter July 5, 1905, at the Post Office at Athens, Ohio, under the Act of Congress of March 3, 1879. Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918. Second-Class Postage Paid at Athens, Ohio.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertisers must conform to policies and regulations established by The Council of the Ohio State Medical Association.

Publication office: 900 East State Street, Athens, Ohio 45701.

Printed by
The Lawhead Press, Inc., Athens, Ohio

VOL. 74 JULY 1978 NO. 7

OHIO Medical Journal

Clinical and Scientific Articles

GILLES DE LA TOURETTE'S SYNDROME 429
David S. Bachman, M.D., Columbus

THE ETIOLOGY OF RETINAL DETACHMENT 433
William H. Havener, M.D., Columbus

CANCER EDUCATION SERIES:
SOFT TISSUE SARCOMAS IN CHILDREN: SURPRISES! 438
William A. Newton, Jr., M.D., Columbus

Proceedings of the 1978 OSMA House of Delegates

FACES 453
Photographs by Linda A. Porterfield, Columbus

INDEX TO RESOLUTIONS 454

PROCEEDINGS OF THE HOUSE OF DELEGATES 457

OSMA OFFICERS, COUNCILORS, AMA DELEGATES AND ALTERNATE DELEGATES, AND STAFF 475

Features

Legislative Update — State.....425
Legislative Update — Federal...426
Journal Advertisers.....434
News 442
New Books Received.....444
New Members.....446
Proceedings of the Council.....478
Obituaries 480
Classified.....483

COVER: Charles O. Butner, M.D., Shiloh, was one of five recipients of Outstanding Entry Awards presented for contributions to the first **Ohio State Medical Journal** Photographic Exhibit. The Exhibit was displayed during the 1978 OSMA Annual Meeting held in May in Dayton. Dr. Butner's photograph, titled "Mabry Mill at Easter," was taken at 10 AM on April 9, 1977 with a Minolta SR-7 camera and Kodacolor ASA 80 film. The mill is a functioning, water-wheeled, power source which grinds meal, cuts lumber, and has overhead power shafts belted to the inside machinery. Located just north of the North Carolina state line on the Blue Ridge Parkway near the Meadows of Dan, Virginia, the mill is usually photographed amid spring leaves and flowers or fall foliage. Turn to page 455 of this issue for the names of the other award-winning physician-photographers. Future issues of **The Journal** will feature their creations.

Copyright 1978. The Ohio State Medical Association. All material subject to this copyright may be photocopied for the noncommercial purpose of scientific or educational advancement.

344281



Life Insurance, With A Difference

WHOLE LIFE

Whole life policies form the base of a responsible life insurance program. In addition to lifetime protection, they include loan provisions, cash and surrender values, and options for payment of proceeds. Whole life policies can meet your business purposes, as well as your need for family protection.

PICO Life's whole life policies include all of these desirable features . . . with one big difference. They were developed and are marketed by a company that really understands your insurance needs, because it is part of an insurance organization formed specifically to serve physicians.

With PICO Life, you can be sure that a whole life policy effectively anchors your life insurance program. You also can be sure that your total program fits your very special situation.

PICO Life. Life Insurance, with a difference.



Pico Life Insurance Company
6100 Channingway Boulevard
Columbus, Ohio 43227
Telephone 614-864-0280

A Subsidiary of Physicians Insurance Company of Ohio

Ohio State Medical Association Clinical and Scientific

Gilles de la Tourette's Syndrome

David S. Bachman, M.D.

Gilles de la Tourette's syndrome has received much attention recently in the neurology literature, but not much has been published in the medical and pediatric journals. It is important that physicians be familiar with this syndrome for several reasons: (1) Articles on Tourette's syndrome have recently appeared in lay magazines, and patients are referring themselves to their physicians with this diagnosis in mind. (2) Tourette's syndrome is now recognized to be an involuntary movement disorder, and psychotherapy has been universally unsuccessful. (3) Most importantly, medical treatment is both available and helpful in many cases.

GILLES DE LA TOURETTE first described the syndrome which bears his name in 1885,[1] but one of his cases had been described earlier by Itard.[2] Tourette's syndrome consists of multiple uncoordinated movements, especially tics, as well as vocal utterances. An essential characteristic for the diagnosis is that the course of the disease is one of fluctuation of the various symptoms over years, some movements or utterances disappearing and changing while others are beginning. Coprolalia (involuntary swearing) is an infamous hallmark of this syndrome, but it is not present in all cases and is not essential for the diagnosis.

Contrary to some opinions in the past, there is no intellectual deterioration accompanying this disease. Furthermore, this entity recently has been recognized as a movement disorder rather than a psychiatric illness as previously thought. Finally, treatment with haloperidol (Haldol®) has represented a major breakthrough in alleviating the symptoms in many of the patients.

Dr. Bachman, Columbus, is a Staff Member, Children's and Riverside Methodist Hospitals; and Clinical Assistant Professor of Pediatrics, The Ohio State University College of Medicine.

Submitted September 16, 1977.

Clinical Manifestations[3]

Tourette's syndrome has its onset in childhood; average age at the beginning of the illness is 7 years, with a range of approximately 2 to 16 years. The syndrome is significantly more common in males, the male-female ratio being about 4:1 in most series. The real incidence of this entity is not known as yet, but with the increasing public awareness, it obviously is not nearly as rare as previously believed. In my experience, about half the patients are self-referred to their physician because of information they have acquired from magazine articles (eg, "Something Terrible Was Happening to Our Son," in *Ladies Home Journal,* September 1976).

The initial symptom is a simple tic, in about one third of the cases; at this stage, it is indistinguishable from the much more common, benign tics of childhood. In fact, in approximately two thirds of the cases, there are multiple tics from the onset. Also, in over one third of the cases, there is a history of vocal sounds or utterances dating from the onset of the disease. The course of Tourette's syndrome is one of exacerbations and remissions extending into adulthood; but there is *no* deterioration of intellect.

The overall clinical course consists of frequent fluctuations in the symptomatology. Emotional stress often is correlated with an exacerbation. The most common manifestations are: simple tics, eye blinking, head twitching, shoulder shrugging, arm jerking, and facial grimacing. More complicated movements, such as jumping, stamping, hitting, and kicking, are present at some time in the course of about half the cases. Even more complex movements (touching the floor, dance-like movements, adjusting the belt, rubbing lips, kissing and fondling people), are present in approximately one-fourth of the patients.

Vocalizations are present at some time in all patients, and consist of such utterances as grunting, snorting, bark-

ing, sniffing, coughing, throatclearing, and shrieking. Actual coprolalia occurs in only about one half the patients, and its appearance may occur years after the onset of the other manifestations of the disease. Average age of onset of coprolalia is around 15 years, the age range being from about 5 years into the 30s.

Neurologic Examination and Laboratory Data[4]

Intelligence is normal in Tourette's syndrome patients, and the disease is not associated with other neurologic entities. About one half the patients are reported to have minor abnormalities on neurological examination. These may include slight drift of an outstretched upper extremity, asymmetry of reflexes, chorea, or mirror movements. Minor abnormalities on electroencephalography, including diffuse disorganization or bilateral sharp activity, are reported to be present in one half to two thirds of these patients. Over two thirds of the patients demonstrate "organic" abnormalities on psychologic testing.

Genetics

Gilles de la Tourette's syndrome has been recognized as an inherited disorder in some cases;[5] however, it is not known in what percentage of the cases this familial occurence exists. Approximately two thirds of the reported cases are in the Jewish population. A significant percentage of the other cases are of Northeast European and Italian heritage. Tourette's syndrome is extremely rare in the Black population. In the familial cases, the mode of inheritance is not at all clear; many pedigrees are consistent with an autosomal dominant, however, that certainly would not explain the predominance of males compared to females with this disease.

Differential Diagnosis

While many entities, particularly the various movement disorders, are mentioned in the differential diagnosis,[6] there are, in fact, very few illnesses which should be confused with Tourette's syndrome. Benign, simple tics is the major entity in differential diagnoses. Simple tics are extremely common, compared to the much rarer Tourette's syndrome. They do not have the continuing and fluctuating course or the vocal utterances. At the onset, however, it often is impossible to distinguish benign tics from the initial manifestations of Tourette's syndrome. In such cases, the course of the disease itself will distinguish these two disorders.

On occasion, Sydenham's chorea may be difficult to distinguish since the choreiform activity occasionally is smaller myoclonic or tic-like movements. In Sydenham's chorea, the documentation of the streptococcal infection or of cardiac disease is not always possible; therefore, such a case could be confused with Tourette's syndrome initially. Again, as the patient is followed, the course of the disease should distinguish these two entities. Other movement disorders, such as Wilson's disease, dystonia musculorum deformans, and Huntington's chorea, should be easily distinguished, clinically, from Tourette's syndrome.

Treatment

First, it is important to recognize that this is not a psychiatric disease, and that psychotherapy is not helpful. Nevertheless, many patients have been seen in psychiatric consultation prior to the diagnosis.

This is an involuntary movement disorder, and the tics are totally uncontrollable by the patient. In fact, the patient frequently is neither aware nor annoyed by the symptomatology. Parents, teachers, and peers often are considerably more distressed by the symptoms than the patient himself. Since these are involuntary, it is important to stress to family members that to reprimand or punish a child to get him to cease the movements does no good and, in fact, may be detrimental.

Most importantly, therapy with haloperidol (Haldol®) is effective in suppressing the symptoms in many cases.[4] I do not use haloperidol in every patient since it is a symptomatic therapy and does not affect the course of the disease. However, if the tics or the vocal utterances are interfering with schooling, this certainly is an indication that therapy should be attempted. Also, many of the youngsters are teased by their peers; this, too, may represent an indication for treatment. I usually begin with very small doses, 0.5 mg once or twice a day, and slowly increase it as needed and tolerated. During the course of the disease, dosage of the medication should be monitored constantly and adjusted according to the fluctuations in the symptoms.

Generic and Trade Name of Drug
Haloperidol—Haldol (McNeil Laboratories)

References

1. Gilles de la Tourette G: Etude sur une affection nerveuse, caracterisée par de l'incoordination motrice, acompagnée d'echolalie et de coprolalie. *Arch Neurol* (Paris) **9**:19-42, 158-200, 1885.
2. Itard JMG: Memoire sur quelques fonctions involontaires des appareils de la locomotion de la prehension et de la voix. *Arch Gen Med* 8:385-407, 1825.
3. Shapiro AK, Shapiro E, Wayne HL: The symptomatology and diagnosis of Gilles de la Tourette's syndrome. *J Amer Acad Child Psychiatry* **12**:702-723, 1973.
4. Sweet RD, Bruun RD, Shapiro AK, et al: The pharmacology of Gilles de la Tourette's syndrome (chronic multiple tic). *Clin Neuropharm* 1:81-104, 1976.
5. Eldridge R, Sweet R, Lake R, et al: Gilles de la Tourette's syndrome: clinical, genetic, psychological and biochemical aspects in twenty-one selected families. *Neurology* **27**: 115-124, 1977.
6. Bruun RD, Shapiro AK: Differential diagnosis of Gilles de la Tourette's syndrome. *J Nerv Ment Dis* **155**:328-334, 1972.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climactenc symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

When impotence is due to androgenic deficiency.

Android® /5 mg. Buccal /10 mg. Oral /25 mg. Oral

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric/eunuchoidism, eunuchism/post-puberal cryptorchidism.



Write for new double-blind study reprints and samples.

BROWN **THE BROWN PHARMACEUTICAL CO., INC.**
2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

A full range of treatment...



As an Air Force physician, you may practice your specialty in modern, well-equipped facilities with a complete support staff.

In addition to the wide spectrum of clinical experience you'll gain, you'll have administrative support to alleviate most of the clerical workload. The type of medicine you will practice is based on the needs of your patients, regardless of their financial status.

For yourself and your family, Air Force medicine will provide reasonable working hours, excellent pay, 30 days of paid vacation each year, and many other benefits.

Consider the Air Force Medical Corps – a reasonable alternative for today's physicians.

For complete information contact:

USAF MEDICAL RECRUITING

Post Office & Court House Bldg.
Rm. 301, Government Square
Cincinnati, Ohio 45202
Phone: 513/381-4141

16101 Snow Rd.
Suite 300
Cleveland, Ohio 44142
Phone: 216/522-4325

Air Force. A great way of life.

The Etiology of Retinal Detachment

William H. Havener, M.D.

Editor's Note.— Physicians not specializing in ophthalmology receive innumerable questions from patients, the family of patients, and friends of patients, who are curious about tht mystery of the pathology of the eye. The author of this article has clearly and succinctly summarized the information regarding retinal detachment. Perhaps the most valuable information for the practicing physician is Dr. Havener's statement: "The patient is not doomed to a lifetime of restricted physical activity following successful retinal detachment surgery. Neither should he restrict the use of his eyes." This should be reassuring information which the physician can pass on to those who query him in his practice, his social life, or his business activities.— **R.L.M.**

MOST PATIENTS AND many physicians assume the cause of retinal detachment is injury. This usually is a false conclusion; injury is not a common cause of retinal detachment.

First, let us discuss how an injury can cause retinal detachment. I believe that the injury must strike the eye directly; either a contusion or a penetrating wound may be adequate to cause retinal detachment. A blow to a remote part of the head or body, even a considerable shock, usually is not adequate to cause retinal detachment. Of course, there are exceptions when a severe shock to the body, as a heavy fall or an automobile accident, seems to have shifted the vitreous enough to cause a retinal detachment soon after. Very few such cases occur in my personal practice.

Types of Injury

Specific types of contusion should be suspected as potentially damaging to the retina. A tennis-ball impact or a blow from a fist or elbow are not uncommon. The tennis player who stands near the net can be struck before his reflexes can protect him. Boxers are particularly vulnerable to eye injuries. We have a dreadfully large number of battered children who are mistreated and beaten by their parents. I've seen several children less than one year of age who were blinded in both eyes by parental beatings. The typical retinal tear caused by a contusion is a disinsertion of the vitreous base and peripheral retina, especially down and temporal, which is the most exposed part of the eye.

Penetrating wounds of the eye may cause retinal holes and subsequent detachments in several ways: (1) a hole at the site of entry if it is located so as to damage the retina; (2) a hole at the site of impact on the retina in the back of the eye; (3) a hole at the site of removal of a foreign body or of surgical repair; and (4) a hole remote from direct trauma and due to traction by damaged vitreous.

Cataract extraction is a special type of penetrating wound which can be caused by a surgeon. The retinal holes caused by cataract extraction may be due to traction transmitted by undue pull upon the zonular fibers. The use of alpha chymotrypsin will minimize such a pull. Incarceration of formed vitreous in the incision often results in traction that can be traced directly to a retinal tear. Inflammatory changes subsequent to cataract extraction damage the vitreous and may lead to massive vitreous retraction and a particularly intractable form of retinal detachment.

Other Causes of Detachment

Having described how direct trauma can harm the eye, let us now emphasize the fact that the great majority of spontaneous retinal detachments are not due to injury. The retina can be considered to be an innocent bystander. The true etiology of the detachment is spontaneous vitreous traction. As a result of degenerative shrinkage of the vitreous, traction is exerted upon the retina, resulting in tears and detachment. There is a strong genetic tendency to such degenerative vitreous changes. Very often, there will be symmetrical damage in both eyes. For example, I

Dr. Havener, Columbus, Professor and Chairman, Department of Ophthalmology, The Ohio State University, College of Medicine.
Submitted December 9, 1978.

remember a 75-year-old man who developed retinal detachment in each eye, three days apart. In each eye, the retinal tear was situated in an upper temporal lattice degeneration. Such symmetrical changes occur so often that when a retinal hole or lattice is found in one eye, the comparable portion of the other retina should be examined for an early symmetrical fault.

Of course, retinal detachments may occur in genetic syndromes, eg, Marfan's syndrome (the "Abraham Lincoln" habitus, with arachnodactyly, dislocated lenses, glaucoma, retinal detachment, cardiac and aortic connective tissue defects); Wagner's vitreoretinal degeneration (a dominantly inherited liquefaction of the vitreous in which the remaining formed vitreous exerts severe focal pull upon the retina, often leading to retinal holes and detachment); and degenerative myopia (the syndrome of severe vitreoretinal deterioration associated with a myopic refractive error). Knowledge of this genetic association will permit you to seek and to find detachments at an earlier stage. Also, you may wish to warn predisposed individuals of the symptoms of retinal detachment and to recommend more frequent examinations.

Vitreous traction damage resulting in retinal holes and detachments may occur in a variety of diseases. For example, branch venous occlusion may cause local gliosis with shrinkage of scar tissue and hole formation. A comparable shrinkage occurs in cases of retinitis proliferans in diabetics and, thus, the holes are much more posterior than in the usual detachment. Other causes of local traction resulting in holes include sickle cell retinopathy, localized retinal inflammations, and Eales' disease (a devastating condition of unknown etiology in which intravitreal growth of retinal vessels occurs. This neovascularization is subject to spontaneous rupture, resulting in severe intraoccular hemorrhages).

Spontaneous degenerative holes apparently not associated with vitreous traction may occur. For example, in senile retinoschisis, tiny holes typically develop in the inner layer, larger holes in the outer layer. A slowly progressive detachment may result when holes exist in both layers of the retina. We have learned that a threatening result of oxygen damage — retinopathy of prematurity — does not end in childhood. Throughout the lifetime of the patient, especially in the second and third decade, eyes with oxygen damage are predisposed to develop multiple small holes in the temporal periphery. Similar, small, multiple holes may occur in degenerative myopia. Eyes with colobomas of the retina develop small holes near the upper edges of the coloboma. Knowledge of the typical locations of such small holes is helpful in detecting them.

Massive vitreous retraction (MVR) is a devastating problem that has been ascribed to the trauma of retinal detachment surgery. I do not agree with this etiologic concept because, in most cases, the condition can be diagnosed before surgery is performed for the retinal detachment. Therefore, it must be attributed to a preexisting etiology and not to the cryotherapy or some other component of the surgery. In my practice, more than half of the cases of MVR are aphakic, whereas less than one fourth of the non-MVR detachments are aphakic. Eyes that are irritated and inflamed following cataract extraction and then detach within several months are particularly likely to result in MVR. While there is insufficient evidence to support the following conclusion, I strongly suspect that vitreous damage incited by an autoimmune reaction to the secondary aqueous or by some type of low-grade inflammation is responsible for MVR. There seems to be a spectrum of damage in which the severe vitreous scarring due to an obvious bacterial endophthalmitis merges indistinguishably with MVR.

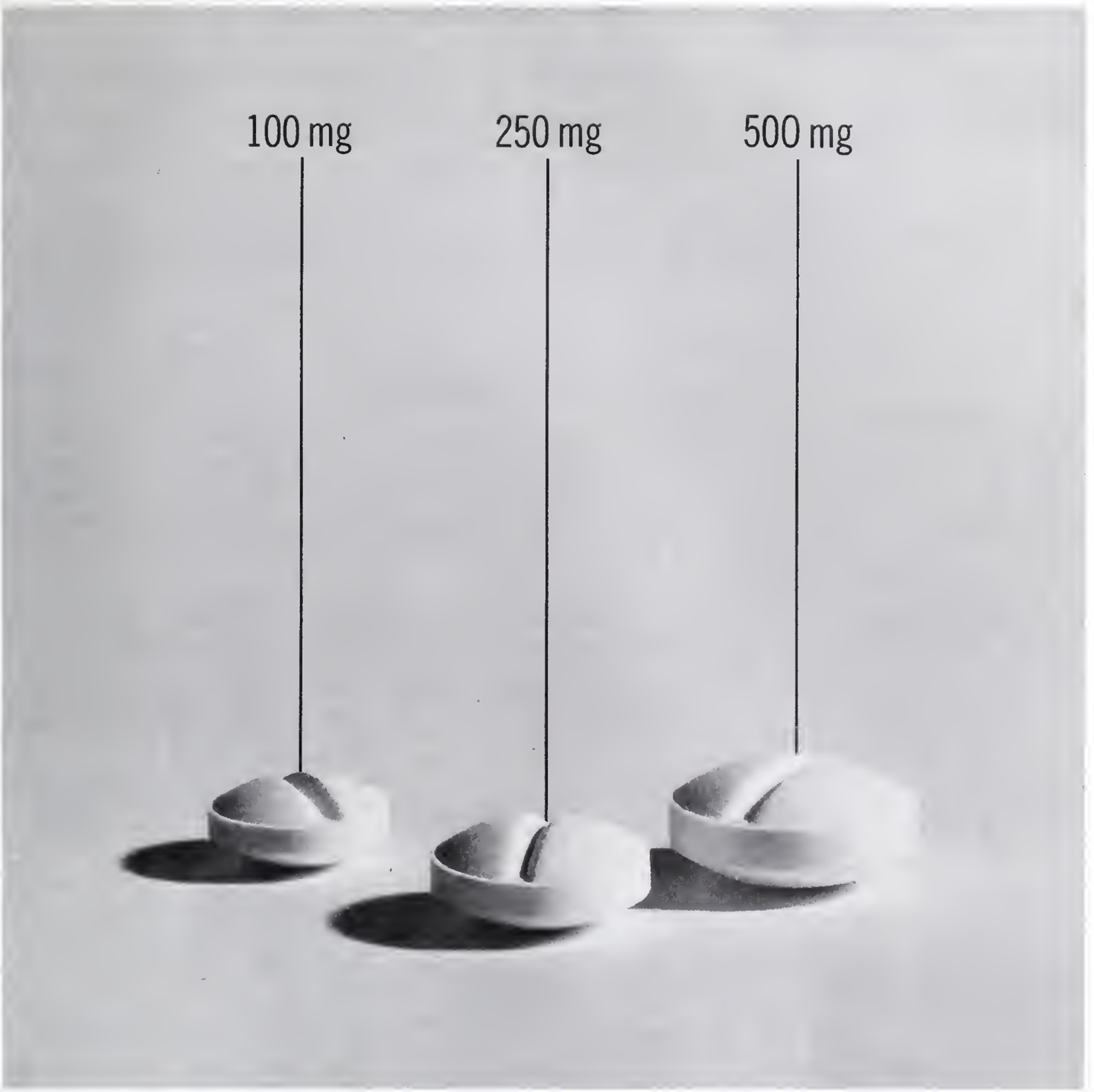
Conclusion

Perhaps the most practical conclusion to be drawn from knowledge of the etiology of retinal detachment is that patients need not be restricted from performing their normal daily activities. The patient is not doomed to a lifetime of restricted physical activity following successful surgery for retinal detachment. Neither should he restrict the use of his eyes. Many patients unnecessarily forego the enjoyment of reading and normal physical activity because they fear they might injure their eyes. Such unnecessary loss of the enjoyment of life is a tragedy that we can and should prevent by properly advising the patient.

One final and important comment: although the etiology of retinal detachment is known to be leakage of fluid through a retinal hole, this does not mean that all retinal holes require treatment. About one of 20 persons of the population has retinal holes or detachments; yet, one in 10,000 persons will suffer a retinal detachment so severe as to threaten eyesight. Therefore, mathematical calculation will show that of 500 persons with asymptomatic retinal holes or detachments, only one of the 500 will require prophylactic therapy to prevent blindness.

Journal Advertisers

Breon Laboratories, Inc. 482
Brown Pharmaceutical Company, Inc. 431, 478, 479
Burroughs Wellcome Co. 439
Daniels-Head & Associates, Inc. 481
Immke Circle Leasing 449
Eli Lilly and Company 441
Mead Johnson 467, 468
Medical Protective Company 481
Menendian Carpets 444
Ohio Medical Indemnity 476
PBP Data Systems 445
Pharmaceutical Manufacturers Association 436, 437
Physicians Insurance Company of Ohio, Inc. 448
PICO Life 428
Practice Productivity 440
Roche Laboratories, Div. of Hoffmann-LaRoche, Inc. ..... 446, 447, Cover 2, Cover 3, Cover 4
Schmidt's Sausage Haus 473
Smith, Kline and French Labs. 450, 451
Stanley H. Kaplan Educational Center 452
Turner & Shepard, Inc. 480
United States Air Force 432
United States Navy 449
Upjohn Pharmaceutical Company 435
Warren-Teed Laboratories 443
Wendt-Bristol Company 477
Windsor Hospital 484



Tolinase®
tolazamide, Upjohn

Please contact your Upjohn representative for additional product information.

Upjohn

J-5695-6

©1977 THE UPJOHN COMPANY

COLBY PROCLAIMS WOMAN SUFFRAGE

Signs Certificate of Ratification at His Home Without Women Witnesses.

MILITANTS VEXED AT PRIVACY.

Wanted Movies of Ceremony, But Both Factions Are

WASHINGTON, Aug. 26, 1920—



Social Security Bill Is Signed; Gives Pensions to Aged, Job

Roosevelt Approves Message Intended to Benefit 30,0 Persons When States Adopt Cooperating Laws–He the Measure 'Cornerstone' of His Economic Progra

WASHINGTON, Aug. 14 The Social Security Bill, p a broad program of unemp insurance and old age p and counted upon to bene 20,000,000 persons, became day when it was signed b dent Roosevelt in the pres those chiefly responsible ting it through Congress.

Mr. Roosevelt called the "the cornerstone in a s which is being but me s comple

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today, 94 to 0, and sent

TRUMAN CLOSES TED NATIONS CONFEREN ITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary session

SIGN the Draf Ends No

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the Secretary of the Army that



PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA
THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION
1155 FIFTEENTH ST, N W, WASHINGTON, D C 20005

OHIO Medical Association Cancer Education Series*

Soft Tissue Sarcomas in Children: Surprises!

William A. Newton, Jr., M.D.

ALTHOUGH CANCER IN CHILDREN is not common, it is the most frequent cause of death due to disease in children over 1 year of age.

Malignant soft tissue sarcomas account for only about 10% of all solid tumors in children (Table 1). Pathologists divide these tumors into many types, but the majority represent variants of rhabdomyosarcoma. Those that cannot be given a specific name because of a lack of identifying mature cellular elements have recently been found to respond to treatment similar to that for rhabdomyosarcoma.[1] The diagnosis of a soft tissue sarcoma is made by biopsy of any suspicious soft tissue mass, and obviously, the earlier the better.

It is surprising that these tumors can arise in almost any site in the body (Table 2). The most common sites are head and neck, extremities, and the genitourinary tract, but these tumors can arise in unlikely locations, such as bile duct, larynx, middle ear, liver, and even the brain.

The most gratifying surprise is the significant improvement in the cure rate of children with this type of cancer. Recent data developed by the Intergroup Rhabdomyosarcoma Study has revealed several important new facts. The stage of disease at diagnosis is obviously critical in determining curability. Stages I, II, III, and IV were defined in this study as: complete resection of primary with no other disease (I), microscopic residual after resection without demonstrated metastases (II), gross tumor left after resection, but metastases free (III), and finally, metastases present at diagnosis (IV). The two-year, disease-free interval for Stages I through IV were 91%, 73%, 54%, and 13%, respectively.[1]

TABLE 1. Type and Percentage of 2,000 Recent Cases of Cancer in Children*

Type	%
Leukemia (all types)	35
Brain tumor (all types)	24
Neuroblastoma	10
Lymphoma	10
Wilms' tumor	6
Soft tissue sarcoma	5
Retinoblastoma	3
Bone	3
Other	4
	100

*From registry data at Children's Hospital, Columbus, Ohio

Treatment has evolved from an almost completely surgical approach to an integrated surgery-radiation-chemotherapy program. The improved survival rate in the past ten years is the result of the more intensive use of radiation and the prophylactic use of effective chemotherapy.[2-4]

With prolonged survival and increased cure rates, more surprising facts concerning these tumors have been revealed. It now is clear that about one third of patients whose primary tumor is in a parameningeal site, eg, nasopharynx, paranasal sinuses, or middle ear, develop direct invasion of the meninges at or within six months of the time of diagnosis.[5] Further, half of the patients with primary tumors of the head and neck, excluding the orbit, who subsequently die, have involvement of the central nervous system (CNS) by extension to the meninges and then into the parenchyma or seeding of the spinal fluid

Dr. Newton, Columbus, is Director of Laboratories and Chief, Hematology Section, Columbus Children's Hospital; and Professor of Pathology and Pediatrics, The Ohio State University College of Medicine.
Submitted April 17, 1977.

The Journal is pleased to publish this series through the cooperation of the OSMA Committee on Cancer and the American Cancer Society, Ohio Division, Inc.

TABLE 2. Primary Site and Percentage of all Stages of Rhabdomyosarcoma in 482 Children*

Site	%
Head and neck (except orbit)	32
Genitourinary	20
Extremities	14
Orbit	11
Trunk	7
Retroperitoneal	7
Other	8

*Unpublished data of Intergroup Rhabdomyosarcoma Study

with formation of tumor around the spinal cord. CNS involvement has been the principal cause of death in these patients.

With significant improvement in survival with radiation therapy and chemotherapy, it has been recommended that surgery be less radical.[4] Primary tumors of the pelvis have responded well to chemotherapy alone, or with added radiation.[6] Extremity lesions, treated by amputation in the past, have been excised with good results in patients whose tumor could be completely removed; however, when tumor removal is incomplete, patients respond poorly, and they have a 50% mortality rate.

Decisions concerning diagnosis and management of these relatively rare childhood tumors must depend on current information and a medical team that is active in the treatment of these tumors. Yesterday's answers cannot apply. The improved results in the management of this type of childhood cancer indicates the importance of centers in which the diagnosis and treatment of childhood cancer is a full-time effort.

References

1. Maurer HM; Moon T; Donaldson M; et al: The Intergroup Rhabdomyosarcoma Study. A preliminary study. *Cancer* 40:2015-2026, 1977.
2. Heyn RM; Holland R; Newton WA; et al: The role of combined chemotherapy in the treatment of rhabdomyosarcoma in children. *Cancer* **34**:2128-2141, 1974.
3. Heyn R; Holland R; Joo P: et al: Treatment of rhabdomyosarcoma in children with surgery, radiotherapy and chemotherapy. *Med Pediatr Oncol* **3**:21-32, 1977.
4. Kilman JW; Clatworthy HW Jr; Newton WA Jr; et al: Reasonable surgery for rhabdomyosarcoma: A study of 67 cases. *Ann Surg* **178**:346-351, 1973.
5. Tefft M; Fernandez C; Donaldson M; et al: Incidence of meningeal involvement by rhabdomyosarcoma of the head and neck in children. A report of the IRS. *Cancer,* to be published.
6. Hayes DM; Ortega J: Primary chemotherapy in the management of pelvic rhabdomyosarcoma in infancy and early childhood, in *Adjuvant Therapy of Cancer* Salmon SE and Jones SE (eds), Amsterdam, Elsevier/North-Holland Biomedical Press, 1977, pp 381-387.



There is a better way to do it... You can find it!

Two New Books Now Available -

PERSONNEL POLICIES AND PROCEDURES FOR THE MEDICAL OFFICE

Do you have personnel policies? Are they written? Are they up to date? Do they provide a clear, concise, competitive statement of what you offer and what you expect from your employees? Are your policies within the guidelines of recent legislation?

- Tells the employee what to expect on these important topics:

Working hours	Personal appearance	Vacation	Outside employment
Holidays	Personal phone calls	Housekeeping	Personal medical care
Smoking	Civic responsibilities	Parking	Compassionate leave

- Reviews policy topics for the manager in depth.
- Prewords sample policies for you on 23 topics.
- Makes you aware of many employer obligations such as:

Sick leave	Medical &	Salary	Summary dismissal
Personal days	dental appointments	Discipline	Other benefits
Probation	Performance review	Termination	Leave of absence



AN EASY WAY TO WRITE PERSONNEL POLICIES!

*

APPOINTMENT SCHEDULING THAT WORKS!

A course in appointment scheduling that enables your medical assistant to rebuild your scheduling system – according to the way you work.

- Your appointment employee learns about your real problems as she explores the improvements.
- The resulting schedule is custom designed for your specialty – the way you do things.
- Respects the patient's time. Keeps him from waiting more time than is reasonable - (usually 20 - 30 minutes maximum).
- Begin getting home on time.
- The workbook becomes a portfolio for continued improvement in future years.
- A simplified "Systems Analysis" approach to an age old problem.



A NEW APPOINTMENT SCHEDULE FOR YOU!

Practice Productivity Inc. **Management Consultants to Physicians**

Please send:

_____ copies of Personnel Policies and Procedures For the Medical Office at $24.50 + $1.80 for shipping and handling:Total $26.30.

_____ copies of Appointment Scheduling That Works! at $14.95 + $1.60 for shipping and handling: Total $16.55.

Send to:

Name _____ Telephone ( ) _____

Practice Name _____ Specialty _____

Address _____ No. of Doctors _____

City _____ State _____ Zip _____ No. of Employees _____

Bank Americard or Master Charge No. _____ Expiration Date ____/____Signature _____

Allow 2 - 3 weeks for delivery. Make check payable and send to:

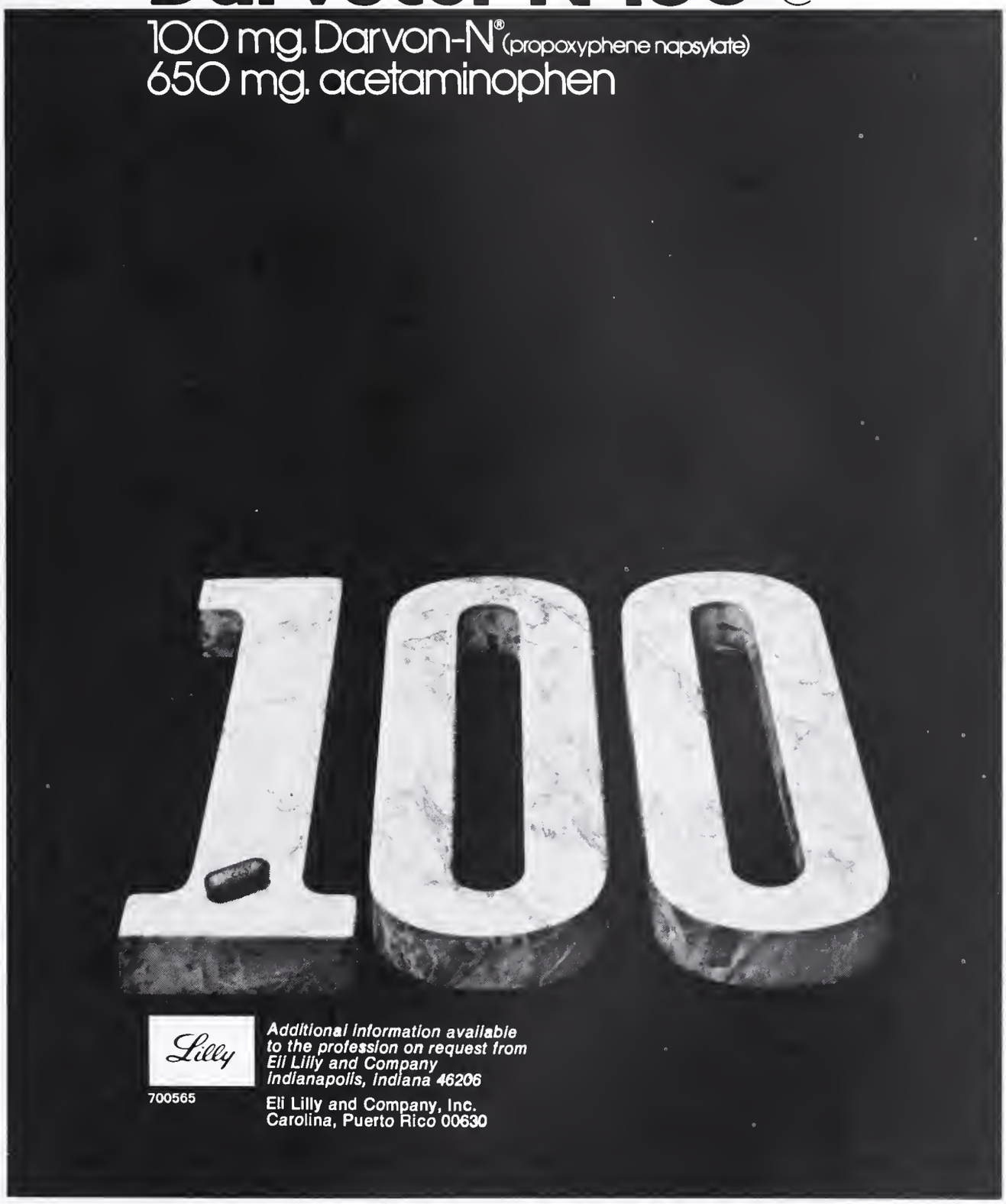
PRACTICE PRODUCTIVITY INC., 2000 Clearview Avenue, Atlanta, Georgia 30340 (404) 455-7344

contains no aspirin

tablets

Darvocet-N® 100 Ⓒ IV

100 mg. Darvon-N® (propoxyphene napsylate)
650 mg. acetaminophen



Lilly

Additional information available to the profession on request from Eli Lilly and Company Indianapolis, Indiana 46206

700565

Eli Lilly and Company, Inc.
Carolina, Puerto Rico 00630

OHIO Medical Association News

Unlicensed Companies Selling Malpractice Insurance in Ohio

It has come to the attention of the Ohio Department of Insurance that certain unlicensed insurance companies are attempting to sell medical malpractice insurance to health care providers in Ohio. Typically, these unlicensed insurers are "offshore" companies, located outside the continental United States.

The Ohio Department of Insurance encourages all health care providers to make certain that their medical malpractice insurer is licensed to sell insurance in Ohio. This will result in several advantages for the policyholder. (1) Licensed insurers are examined periodically by the Department to assure their financial stability. (2) Agents of licensed insurers must pass the Department's examination to ensure they have adequate knowledge to sell insurance. (3) In the event a policyholder or claimant experiences difficulty over payment of a claim, the Department's Policyholder Service Division can often be of assistance in settling claims. Additionally, purchasers of medical malpractice insurance from unlicensed insurers may be subject to a tax in the amount of 5% of the premium.

The Department maintains a list of licensed insurance companies in Ohio. To obtain a copy of this list, please write the Ohio Department of Insurance, Examination Division, 2100 Stella Court, Columbus, Ohio 43215.

Antivenin Information Available Daily From Oklahoma Center

The Antivenin Index Center is a current catalog of snake-bite antivenins stocked in North American zoos, laboratories, and related institutions. The Center provides a 24-hour-a-day retrieval service on antivenins available for the treatment of venomous snake-bite from native and exotic species. The Index is limited to sera currently stocked by participating institutions. Also, full data is provided on telephone numbers and personnel to obtain emergency supplies of antivenins.

The Center does not stock antivenin; rather, it serves as an index for emergency information on available antivenins. To use this service:

1. Obtain both the scientific name (genus and species) and the common or vernacular name of the snake involved (ie, Dendroaspis polylepis, black mamba). Knowledge of the correct scientific name is almost indispensable in the proper selection of the appropriate antivenin.
2. Call the Antivenin Index Center in Oklahoma City, phone: 405/271-5454, for the following information:
   - ★ Antivenins applicable to your snake-bite which currently are stocked in North American institutions.
   - ★ Locations of available stocks nearest to you, amounts currently in stock, and expiration dates.
   - ★ Emergency telephone numbers and names of key personnel for obtaining the antivenins from the listed institutions.
3. Contact your nearest supply and make arrangements for emergency delivery of antivenin.

PICO Reduces Auto Policy Rates

The Physicians Insurance Company of Ohio (PICO) has announced a 15% rate reduction on its Family Automobile Insurance policies. Effective June 15, 1978 on new policies written and on the renewal dates of policies currently in effect, the rate reduction makes PICO competitive with virtually all of the companies offering similar coverage.

New Hemoglobin Center at Cleveland Hospital

Rainbow Babies and Childrens Hospital, Cleveland, has established a new Hemoglobin Center for the diagnosis and treatment of children with blood disorders. The primary focus of the new center is on sickle cell disease and Cooley's anemia. Sickle cell disease primarily strikes Black Americans, but it is also found in Caucasians from the Mediterranean area, the Middle East, and parts of India. Cooley's anemia is more commonly found in families of Greek and Italian origin. These diseases have no cure, but early intervention and treatment of complications minimize problems

Kamran Tebbi, M.D., pediatric hematologist, will direct the center. Dr. Tebbi is Assistant Professor of Pediatrics and Associate Director of the Pediatric Hematology Laboratory at Case Western Reserve University. Rainbow Babies and Childrens Hospital is the children's medical and surgical center of University Hospitals and Case Western Reserve University School of Medicine.

Final Blood Donor Classification Labeling Requirements Issued

The Food and Drug Administration has issued final Blood Donor Classification Labeling Requirements which became effective May 15, 1978. The new rules amend the existing biologics regulations by requiring that each container of whole blood and blood components intended for transfusion bear the label statement "paid

(continued on page 444)

Time is the test of all things.

1954
1978



BRIEF SUMMARY

Indications: Oral potassium therapy for the prevention and treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. May be used in the treatment of cardiac arrhythmias due to digitalis intoxication.

Contraindications: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause.

Precautions: Potassium intoxication by oral administration rarely occurs in patients with normal kidney function, however, potassium supplements must be administered with caution, since the amount of the deficiency or daily dosage is not accurately known. Frequent checks of the clinical status of the patient, and periodic ECG and/or serum potassium levels should be made. High serum concentrations of potassium ion may cause death through cardiac depression, arrhythmias or arrest. This drug should be used with caution in the presence of cardiac disease.

In hypokalemic states, especially in patients on a low-salt diet, hypochloremic alkalosis is a possibility that may require chloride as well as potassium supplementation.

Adverse Reactions: Nausea, vomiting, diarrhea, and abdominal discomfort have been reported. The most severe adverse effect is hyperkalemia.

Overdosage: Potassium intoxication may result from overdosage of potassium or from therapeutic dosage in conditions stated under "Contraindications". Hyperkalemia, when detected, must be treated immediately because lethal levels can be reached in a few hours.

Kaon® Elixir
(potassium gluconate)
20 mEq per 15 ml

WARREN-TEED
LABORATORIES, INC.
DIVISION OF **AORIA LABORATORIES INC.**
COLUMBUS, OHIO 43215

News *(continued)*

donor" or "volunteer donor." Donor-classification labeling requirements will not apply to Source Plasma (Human) or plasma derivatives.

The regulations include definitions of paid and volunteer donors. These definitions essentially adopt the definitions suggested by the American Association of Blood Banks:

(i) A paid donor is a person who receives monetary payment for a blood donation.

(ii) A volunteer donor is a person who does not receive monetary payment for a blood donation.

(iii) Benefits, such as time off from work, membership in blood assurance programs, and cancellation of nonreplacement fees that are not readily convertible to cash, do not constitute monetary payment within the meaning of this paragraph . . .

Further information may be obtained from Joe K. Holloway or Al Rothschild, Bureau of Biologics (HFB-620), Food and Drug Administration, Department of Health, Education, and Welfare, 8800 Rockville Pike, Bethesda, Maryland 20014, phone: 301/443-4626.

Opportunity Directory Published

A new directory of medical-practice opportunities for physicians, the *Opportunity Directory,* has been published. Important features are the computer-generated indexes which facilitate finding the most suitable opportunity. Another new publication is the *Physician Directory,* which contains anonymous resumes of physicians seeking opportunities. Both directories will be published quarterly. More information regarding these publications is available from the Physicians' Placement Service, AMA Headquarters, 535 North Dearborn Street, Chicago, Illinois 60610, phone: 312/751-6000.

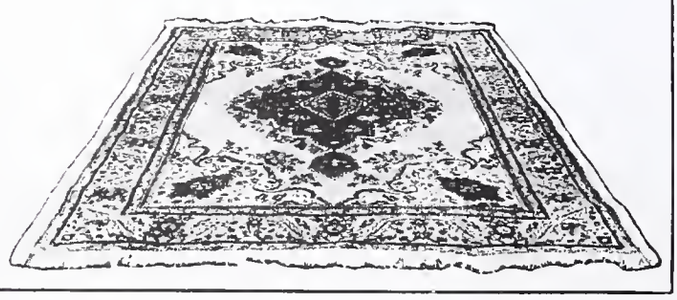
In Columbus
for over 65 years, since 1909,
K. A. Menendian
has been known for
the finest quality and best values in
ORIENTAL RUGS.

We carry a complete selection of rugs from mats to mansion sizes. Over 1500 rugs in stock from Iran, India, China, Pakistan, Turkey, etc.

See over 4,000 samples in our newly remodeled carpet showroom from Karastan and other fine mills.

We specialize in Oriental rug cleaning and repairing.

K.A.Menendian
1090 West Fifth Avenue
294-3345



United States Supreme Court Upholds 1974 Health Planning Law

Without opinion, the United States Supreme Court affirmed the ruling of a lower court upholding the constitutionality of the 1974 health planning law. The AMA, the States of Nebraska and North Carolina, and the North Carolina Medical Society had appealed to the Supreme Court after a federal court in Raleigh, North Carolina ruled last August that the law is constitutional and that Congress can attach any conditions it wants to the distribution of federal funds. The plaintiffs had argued that the law's requirement that states pass certificate-of-need legislation before receiving federal grants was an unconstitutional violation of states' rights. The Supreme Court took this action in April.

T.V. Violence Curtailed in 1977

According to a study partially funded by the AMA, television violence dropped sharply in 1977 from the record high reached in 1976. Conducted by researchers at the University of Pennsylvania Annenberg School of Communications, the study also shows that NBC ranked as the most violent network in the 1977 fall season, while ABC edged out CBS as the least violent. However, despite the decline, violence still appeared in more than two thirds of all prime-time programs and nine of ten weekend morning programs broadcast in the fall of 1977.

New Books Received

Clinical Concepts of Fetal Heart Rate Monitoring, by Marshall Klavan, M.D.; Authur T. Laver, M.D.; and Mary A. Boscola, R.N.; 113 pp with illus, $10, Waltham, Mass, Hewlett-Packard Co, Medical Products Group, 1977.

Emergent Care of the Burn Victim, by Irving Feller, M.D.; Claudella A. Jones, R.N.; and Kathryn E. Richards, M.D., 76 pp with illus, Ann Arbor, Mich, National Institute for Burn Medicine, 1977.

Psychodynamics of Drug Dependence, edited by Jack D. Blaine, M.D., and Demetrios A. Julius, M.D., 187 pp, Natl Institute on Drug Abuse, Research Monograph Series 12, May 1977. Available from Supt of Documents, US Govt Printing Office, Washington DC, Stock #017-024-00642-4.

Take Care of Yourself. A Consumer's Guide to Medical Care, by Donald M. Vickery, M.D., and James F. Fries, M.D., 269 pp with illus, Reading, Mass, Addison-Wesley Publishing Co, 1977.

Medical Data-Plan®

We're not offering you just a computerized billing system. We're offering you a way to plan the future of your practice.



Medical Data-Plan is computerized system r getting bills out, rocessing insurance rms, speeding up ash flow and improving ollections.

It also gives you e information you eed to plan the future of our practice . . . 3 years, years, 10 years om now.

Based on a steady ow of accurate, timely mputer reports, your usiness manager can make ound recommendations n personnel, equipment, naterials, facilities and nore. Medical Data-Plan an show you what your ractice has been doing— nd what it should be doing.

Clip this coupon to receive information or to arrange an appointment with a Data-Plan representative.

Data-Plan

OM

Medical Data-Plan
Box 7947, Madison, Wisconsin 53707

Name _____

Address _____

City _____

State _____ Zip _____

Check one or both boxes below:

☐ Please mail me more information about Medical Data-Plan.

☐ Please have a representative contact me. My phone number is:

_____
(area code) (number)

Medical Data-Plan, Box 7947, Madison, Wisconsin 53707

The Ohio State Medical Association

New Members

BUTLER
John V. Simpson, Morehead, Ky.

CUYAHOGA (Cleveland)
Alvito F. Carrasco
Joseph E. Colizoli
Randall C. Deehring
Carl C. Gill
Peter P. Kay
Lonnie Marsh II
Charles C. Shin

FRANKLIN (Columbus unless noted)
Li Chuen Chen
Frank R. Fletcher
Larry Lytle, Worthington
Kathe Louise Mueller
Joseph C. Schultz
Albert J. Weaver

HAMILTON (Cincinnati)
John H. Wehby

JEFFERSON (Steubenville)
Patrick Macedonia

MEDINA (Medina)
Helen Mary Torok

MONTGOMERY (Dayton unless noted)
Norman H. Blass
Thomas Henry, Englewood
Rosa Chua Ho
Dalisay M. Lustre
P. David Suberviola
Steven Yowell, Trotwood

SENECA (Tiffin)
Dong Soo Park

SUMMIT (Akron)
Nirmala Apte
Ashok J. Desai
Bharati A. Desai
Marvin Leedy
Arne Melby III

TRUMBULL (Warren)
Carlos A. Ricotti

Librax®
Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

ROCHE
Roche Products Inc.
Manati, Puerto Rico 00701



In treating irritable bowel syndrome*

Enhance your therapeutic expectations with

Librax®

Each capsule contains
5 mg chlordiazepoxide HCl
and 2.5 mg clidinium Br.

antianxiety/antispasmodic/antimotility

Librax is unique among G.I. medications in providing the specific antianxiety action of LIBRIUM®(chlordiazepoxide HCl) as well as the potent antispasmodic and antimotility actions of QUARZAN®(clidinium Br) for adjunctive therapy of irritable bowel syndrome.

ROCHE

*Librax has been evaluated as possibly effective for this indication.
Please see brief summary of prescribing information on preceding page.



Should Be Your Automobile Insurance Company

PICO's objective is to more effectively meet the insurance needs of OSMA members. That includes Family Automobile Insurance, as well as medical professional liability insurance and other forms of property and casualty coverages.

PICO has just reduced the rates for its Family Automobile Insurance by 15 percent*. This means PICO's rates now are competitive with virtually all companies offering similar coverage. And, of course, you continue to receive the broad coverages and high quality services that PICO features in all of its insurance programs.

Compare PICO's rates and services. You'll see why PICO should be your automobile insurance company.

PICO. Owned by physicians. To serve physicians.

* Effective June 15, 1978, on new policies written and on the respective renewal dates of policies currently in effect.

Physicians Insurance Company of Ohio
6100 Channingway Boulevard
Columbus, Ohio 43227
Telephone Toll Free 1-800-282-7515



When was the last time your practice gave you a good night's sleep?

We're not talking about sleep that comes from sheer exhaustion.

We're talking about the kind of sleep that comes from knowing you practiced medicine today the way it was meant to be practiced. Of giving your patients the very best in medical care. With no compromises.

And a sleep that comes from knowing you won't be spending all of tomorrow morning filling out Medicare insurance forms, or attending to a myriad of other time-consuming, non-medical duties.

But there is a practice that offers an alternative to the kind of medicine you're now practicing. A practice in the U.S. Navy.

The Navy physician.

As a Navy physician, we feel your time is too valuable to spend on administrative details. So they're kept to a minimum. Instead, a highly trained staff of professionals attends to the paperwork. The end result is that almost all your time can be spent practicing medicine.

A challenging practice.

You'll be given a practice that's as varied and challenging as any you'll find in a civilian setting. You'll be treating active duty personnel as well as their dependents and retired personnel.

Insurance.

A recent Act of Congress now makes it unnecessary for federally employed physicians to carry high cost insurance. As a practicing Navy physician, you will receive professional liability protection under the Federal Tort Claims Act.

Other benefits.

There are plenty of other great benefits that go with being a Navy physician. Good pay— $30,000 to start, more, depending on your experience. A family life with time for your family. Associating with other highly motivated physicians. Even 30 days' paid vacation a year.

But the best way to get all the facts is to mail the coupon, or call the Medical Recruiter, toll-free, 1-800-282-1288.

Be the doctor you want to be. In the Navy.

IMMKE CIRCLE LEASING INC

Endorsed Leasing Company
Of The Ohio State Medical Association

Immediate delivery on many 1978 models

We lease all foreign and domestic makes and models including Mercedes, Jaguar, Porsche, etc.

Many people think of leasing as just automobiles.
We do that too, but, in addition, we want to lease you any professional equipment.

Immke Circle Leasing, Inc.
32 South Fifth Street
Columbus, Ohio 43215

Telephone 614-228-1701 or Toll Free 1-800-282-0256

ANCEF® IV IM

brand of sterile

CEFAZOLIN SODIUM

(LYOPHILIZED)

For serious respiratory infections

due to susceptible indicated organisms



Bactericidal *in vitro* against susceptible strains*

IV/IM Dosage Flexibility

'Ancef' may be given either IM or IV at the same dosage schedule.

Most infections can be treated with 500 mg. to 1 gram every 8 hours.

(See complete prescribing information in *PDR* or SK&F literature for full dosage instructions.)

Well Tolerated

Infrequent phlebitis; no nephrotoxicity reported. Transient rises in BUN, SGOT, SGPT and alkaline phosphatase have been reported without clinical evidence of renal or hepatic impairment.

Before prescribing, see complete prescribing information in SK&F literoture or *PDR*. The following is o brief summory.

Indicotions: Ancef® (sterile cefazolin sodium, SK&F) is indicated in the treatment of the following serious infections due to susceptible organisms.

***Respirotory tract infections** due to *Streptococcus (Diplococcus) pneumoniae*, *Klebsiella* species, *Hemaphilus influenzae*, *Staphylococcus* aureus (penicillin-sensitive and penicillin-resistant), and group A beta-hemolytic streptococci.

Injectable benzathine penicillin is considered to be the drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever.

'Ancef' is effective in the eradication of streptococci from the nasopharynx; however, data establishing the efficacy of 'Ancef' in the subsequent prevention of rheumatic fever are not available at present.

Genitourinory troct infections due to *Escherichia coli, Proteus mirabilis, Klebsiella* species, and some strains of enterobocter and enterococci.

Skin and soft-tissue infections due to *S.* aureus (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci and other strains of streptococci.

Bone and joint infections due to *S.* aureus.

Septicemio due to *Str. pneumoniae, S.* aureus (penicillin-sensitive and penicillin-resistant), *P. mirabilis, E. coli,* and *Klebsiella* species.

Endocorditis due to *S.* aureus (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci.

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causotive organism to 'Ancef'.

Controindications: 'Ancef' is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: BEFORE CEFAZOLIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS.

SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence of portial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Antibiotics, including 'Ancef', should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Usage in Pregnancy—Safety of this product for use during pregnancy has not been established.

Usage in Infants—Safety for use in prematures and infants under one month of age has not been established.

Precoutions: Prolonged use of 'Ancef' may result in the overgrowth of non-susceptible organisms. Careful clinical observation of the potient is essential.

When 'Ancef' is administered to adults or children with low urinary output because of impaired renal function, lower daily dosage is required (see dosage instructions in the package literature).

A false-positive reaction for glucose in the urine may occur with Clinitest® tablets; use glucose enzyme-type reagents.

Adverse Reactions: The following reactions have been reported. Drug fever, skin rash, vulvar pruritus, eosinophilia, neutropenia, leukopenia, thrombocythemia, and positive direct and indirect Coombs tests have occurred. Transient rise in SGOT, SGPT, BUN, and alkaline phosphatase levels has been observed without clinical evidence of renal or hepatic impairment. Nausea, anorexia, vomiting, diarrhea, and oral candidiasis (oral thrush) have been reported. Pain at the site of injection after intramuscular administration has occurred, some with induration. Phlebitis at the site of injection has been noted. Other reactions have included genital and anal pruritus, genital moniliasis, and vaginitis.

Administration ond Dosoge: 'Ancef' may be administered intramuscularly or intravenously after reconstitution. See the package literature for reconstitution procedures.

See the package literature for dosage recommendations.

How Supplied: 'Ancef' (sterile cefazolin sodium, SK&F)—supplied in vials equivalent to 250 mg., 500 mg. or 1 gram of cefazolin; in "Piggyback" Vials for intravenous admixture equivalent to 500 mg. or 1 gram of cefazolin; and in Pharmacy Bulk Vials equivalent to 5 grams or 10 grams of cefazolin.

ANCEF® IV IM

brand of sterile

CEFAZOLIN SODIUM

(LYOPHILIZED)

Injection: 250 mg., 500 mg. and 1 gram vials

Smith Kline &French Laboratories

Philadelphia, Pa.

SK&F

a SmithKline company



PREPARE FOR YOUR:

National Medical Boards
(PART I, II, OR III)
ECFMG–VQE–FLEX
National Dental Boards
(PART I OR II)
Nursing Licensure Examination

- Voluminous home-study notes on areas covered on NMB-I & NDB-I & II.
- Sample questions accompanied by comprehensive teaching tapes to use at any of our tape centers.
- Materials constantly updated and revised.
- Study at your own pace via tape recordings at centers most convenient for you.
- Forty years of experience and success in the field of test preparation.
- When it comes to preparation, more students enroll in our courses because . . . THERE IS A DIFFERENCE!



Stanley H. KAPLAN
EDUCATIONAL CENTER
Test preparation specialists since 1938.

For more information or for other locations, call Toll Free: 800/223-1782.

CLEVELAND AREA:
14055 Cedar Road
Cleveland 44118 Phone: 216/371-0035

COLUMBUS AREA:
1890 Northwest Boulevard
Columbus 43212 Phone: 614/486-9646

CINCINNATI AREA:
309 Ludlow Avenue
Cincinnati 45220 Phone: 513/281-1818

Other Stanley H. Kaplan locations in Albuquerque, Ann Arbor, Atlanta, Austin, Baltimore, Birmingham, Boston, Champaign, Charleston, Chicago, Cleveland, Columbus, Dallas, Denver, Detroit, Durham, East Brunswick, El Paso, Gainesville, Houston, Indianapolis, Kansas City, Los Angeles, Louisville, Lubbock, Madison, Memphis, Miami, Milwaukee, Nashville, New Haven, New Orleans, Oklahoma City, Omaha, Palo Alto, Philadelphia, Phoenix, Pittsburgh, River Falls, St. Louis, Salt Lake City, San Antonio, San Diego, San Francisco, Seattle, Tampa, Washington D.C. Stanley H. Kaplan locations abroad Lugano, Switzerland San Juan, Puerto Rico. Toronto, Canada
Other planned locations Allentown, Little Rock, Minneapolis, Portland

©1978 STANLEY H. KAPLAN ALL RIGHTS RESERVED







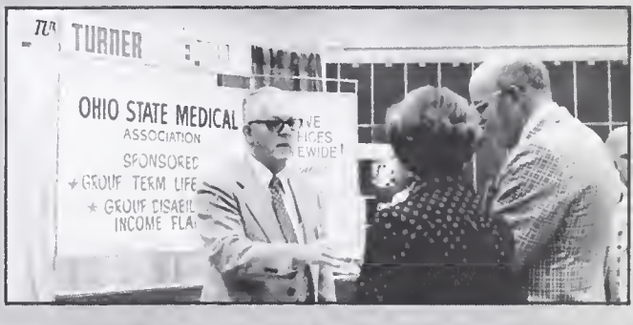














hotographs by Linda A. Porterfield
See page 455 for identification)

RESOLUTION NO. . . .	SUBJECT AND SPONSOR	REFERRED TO RESOLUTIONS COMMITTEE

Editor's Note: Report of Resolutions Committee No. 1 begins on page 461; Resolutions Committee No. 2 on page 463; and Resolutions Committee No. 3 on page 470. This index is for reference purposes only and is not part of the Official Proceedings of the 1978 House of Delegates. L.A.P.

01	**Prior Review of Resolutions** (Board of Directors, Academy of Medicine of Cleveland)	1
02	**Grass Roots Representation to AMA** (Summit County Medical Society)	1
03	**State of the State** (Summit County Medical Society)	1
04	**Automatic Termination of Membership** (Summit County Medical Society)	1
05	**Composition of Resolutions Committees** (Huron County Medical Society)	1
06	**Obtaining Lists from OSMA Staff** (Huron County Medical Society)	1
07	**Amendment to OSMA Bylaws "Resolutions Committee"** (Huron County Medical Society)	1
08	**Utilization of County Society Leadership by OSMA** (Summit County Medical Society)	1
09	**H.R. 1818** (Stark County Medical Society)	1
10	**OSMA Interim Meeting** (Stark County Medical Society)	1
11	**Reapportionment of the Districts** (M. Brodie James, M.D., OSMA Member at Large)	1
12	**Speaker and Vice Speaker for the House of Delegates** (Lima and Allen County Academy of Medicine)	1
13	**AMA Opinion Poll** (Ross County Medical Society)	1
14	**Special Meetings of OSMA House of Delegates** (P. John Robechek, M.D., Cuyahoga County & Robert R. Clark, M.D., Summit County)	1
15	**Interim Sessions of OSMA House of Delegates** (Academy of Medicine of Cleveland)	1
16	**OSMA Dues Increase** (William M. Wells, M.D., President, OSMA)	1
17	**Funds for Defense** (C. Edward Pichette, M.D., Sixth District Councilor, OSMA)	1
18	**OSMA Election Rules** (James B. Evans, M.D., Member, Montgomery County Medical Society)	1
19	**MSMS vs. BC/BS** (Stark County Medical Society)	2
20	**PICO** (Stark County Medical Society)	2
21	**Accountability** (Ross County Medical Society)	2
22	**Confidentiality** (Academy of Medicine of Cleveland)	2
23	**Insurance Coverage for Psychiatric Patients** (Academy of Medicine of Cleveland)	
24	**Collateral Source** (Academy of Medicine of Cleveland)	
25	**Tort Reform** (Academy of Medicine of Cleveland)	
26	**Counter Suits** (Academy of Medicine of Cleveland)	
27	**Prompt Payment of Insurance Claims** (Academy of Medicine of Cleveland)	
28	**Amendments to H.B. 682** (Academy of Medicine of Cleveland)	
29	**OMI Letters** (Council of the Mahoning County Medical Society)	
30	**PICO** (Academy of Medicine of Columbus and Franklin County)	
31	**PICO** (Montgomery County Medical Society)	
32	**Cost Containment** (Academy of Medicine of Cleveland)	
33	**Voluntary Cost Containment** (Academy of Medicine of Columbus and Franklin County)	
34	**Ohio Medical Indemnity Fair Fee Support Program** (Scioto County Medical Society)	
35	**Doctors of Osteopathy** (Mahoning County Medical Society)	
36	**Contraceptive and Prenatal Services for Minors** (OSMA Committee on School Health)	
37	**Proposed New Code of Medical Ethics** (Huron County Medical Society)	
38	**National Health Insurance— HR 1818** (Huron County Medical Society)	
39	**Public Understanding** (Miami County Medical Society)	
40	**Task Force to Study a State and Federal Tax Credit Reimbursement Plan** (Miami County Medical Society)	
41	**Sale of Cigarettes by Hospitals** (Joseph L. Kloss, M.D., Delegate, Summit County Medical Society)	
42	**Health Planning Guidelines** (Academy of Medicine of Cleveland)	
43	**Certificate of Need** (Academy of Medicine of Cleveland)	
44	**Rights of Lay Boards of Trustees to Mandate Policy to Medical Staffs** (Academy of Medicine of Cleveland)	
45	**Community Mental Health Centers** (Academy of Medicine of Cleveland)	
46	**Definition of Psychosis and Mental Deficiency** (Academy of Medicine of Cleveland)	
47	**Guidelines of Medical Staff Bylaws** (Academy of Medicine of Cleveland)	
48	**Contraceptive Services for Minors** (Academy of Medicine of Cleveland)	

Resolutions

RESOLUTION NO. . . .	SUBJECT AND SPONSOR	REFERRED TO RESOLUTIONS COMMITTEE
49	**Supervision of Physician Extenders** (Edward G. Kilroy, M.D., Delegate, Cuyahoga County)	3
50	**To Create an Ad-Hoc Committee on Foreign Medical Graduates, Cosponsor with a Medical School or Any Other School, Courses in the Basic Sciences and English for Foreign Medical Graduates** (Felino V. Barnes, M.D., Delegate, Cuyahoga County)	3
51	**Certificate of Need Denies Local Health Care Rights** (Academy of Medicine of Columbus and Franklin County)	3
52	**Health Planning is a Community Right** (Academy of Medicine of Columbus and Franklin County)	3
53	**Principles of Medical Ethics** (Academy of Medicine of Columbus and Franklin County)	3
54	**Establishment of National PSRO Guidelines** (Emergency Resolution) (Stark County Medical Society)	1
55	**Funds for Defense** (Emergency Resolution) (Council of the Ohio State Medical Association)	1
56	**Physicians Responding to Emergencies in Hospitals** (Emergency Resolution) (Academy of Medicine of Cleveland)	2
57	**Continuation of General Practice Residencies** (Emergency Resolution) (Portage County Medical Society)	3
58	**Ohio Department of Public Welfare (Medicaid Division) Pre-Admission Review Forms** (Emergency Resolution) (Portage County Medical Society)	3
59	**OMI Necessity Program** (Emergency Resolution) (Stark County Medical Society)	2

1978 Outstanding Entries Journal Photographic Exhibit

George W. Waylonis, M.D., Columbus; B/W; Title: "Old Mill Road."
George W. Waylonis, M.D., Columbus; B/W; Title: "Beached For The Night."
Dwight Tunri, M.D., Dayton; 4/C; Title: "Prelude To Winter."
Patricia A. Foust, M.D., Bolivar; 4/C; Title: "God's Painting."
Charles O. Butner, M.D., Shiloh; 4/C; Title: "Mabry Mill At Easter."
Henry Bachman, M.D., McConnelsville; 4/C; Title: "Sunset Over The Ding Darling Bird Sanctuary."

Photograph identification for page 453 *(left to right):*

ROW ONE: (1) The Gaughan daughters look on as their father takes the oath of office from Past President George N. Bates, M.D., Toledo. (2) Dr. and Mrs. John H. Budd, Cleveland, and Dr. and Mrs. William M. Wells, Newark. (3) Director of the Ohio Department of Health, John H. Ackerman, M.D., Columbus, and Lt. Col. Alan D. Dawson, USAF MC, Florida.

ROW TWO: (1) Newly elected President-Elect Thomas W. Morgan, M.D., Gallipolis, and Secretary-Treasurer Robert G. Thomas, M.D., Elyria. (2) W. J. Lewis, M.D., Dayton, directs the Montgomery County Medical Society Glee Club. (3) Robert N. Smith, M.D., Toledo. (4) Oscar W. Clarke, M.D., Gallipolis, and Jack Schreiber, M.D., Canfield.

ROW THREE: (1) Howard C. Rempes, Jr., Executive Secretary, Mahoning County Medical Society; William E. Sovik, M.D., Youngstown; and Henry H. Clapper, M.D., Canton. (2) Herman I. Abromowitz, M.D., Dayton, and John J. Gaughan, M.D. (3) President William M. Wells, M.D., presents Steven M. Dosick, M.D., Toledo, the Clinical Investigation Silver Award for his exhibit "Non-Invasive Carotid Screening— a Comparison" as John J. Gaughan, M.D., Cleveland, observes.

ROW FOUR: (1) OMPAC Chairman H. William Porterfield, M.D., Columbus, and Mrs. Albert May, OSMA Auxiliary President. (2) Chairman of the Tellers and Judges Committee William B. Selnick, D.O., Loveland, and committee member Carl Frye, M.D., Newark. (3) Newly elected Councilor H. Judson Reamy, M.D., Dover, and OSMA Associate Executive Director Herbert E. Gillen.

ROW FIVE: (1) OSMA Staff members Mrs. Beth Fraley, Joe Dusina, and Mrs. Irene Icenhower. (2) The Montgomery County Medical Society Information Booth. (3) Dr. and Mrs. James C. McLarnan, Mt. Vernon, visit the Exhibition Hall.

ROW SIX: (1) Mrs. Gaughan; AMA President John H. Budd, M.D.; OSMA Auxiliary President Mrs. Albert May, Marion; OSMA President-Elect John J. Gaughan, M.D.; Mrs. Budd; and OSMA Auxiliary President-Elect Mrs. Emil L. Barrows, Cincinnati. (2) James J. Otis, M.D., (right), Celina, stops at the scientific exhibits. (3) Vincent T. LaMaida, M.D., Cleveland, and John E. Albers, M.D., Cincinnati, present the Bronze Teaching Award to Thomas S. Berger, M.D., Cincinnati (center), for his exhibit "Peripheral Nerve Entrapment Neuropathies."

Photograph identification for page 456 *(left to right):*

ROW ONE: (1) Paul E. Lyon, M.D., Marion; Carl G. Thompson, Jr., M.D., Cincinnati; and Stanley J. Lucas, M.D., Cincinnati, Chairman of Reference Committee No. 3. (2) A standing vote featuring Franklin and Summit Counties. (3) Nicholas G. DePiero, M.D., Garfield Heights.

ROW TWO: (1) AMA President John H. Budd, M.D., and OSMA President-Elect John J. Gaughan, M.D., and the Cuyahoga County ladies. (2) OSMA Director of Field Service Robert E. Holcomb; John H. Sanders, M.D., Fairview Park; and William J. Keating, M.D., Cleveland.

ROW THREE: (1) Leonard K. Smith, M.D., Kenton; C. Edward Pichette, M.D., Youngstown; and Richard Wisely, M.D., Toledo. (2) Dr. and Mrs. Wells receive their medallions from Past President George N. Bates, M.D. (3) Chairman of the Credentials Committee Richard L. Fulton, M.D., Columbus, and David J. Hickson, M.D., Mt. Gilead, Chairman of Resolutions Committee No. 1.

ROW FOUR: (2) Artist Robert Spencer, Columbus; Vincent T. LaMaida, M.D., Cleveland; Arthur J. Cloran, D.D.S., East Liverpool; John E. Albers, M.D., Cincinnati; and Richard E. Hartle, M.D., Lancaster, at the Clinical Research Special Award exhibit "The Cloran Mouthstick." (3) William H. Gates, M.D., and Ranjit Rath, M.D., Cincinnati.

ROW FIVE: (1) W. J. Lewis, M.D., Dayton; Sen. Tony Hall, Dayton; OSMA Director of State Legislation D. Brent Mulgrew, J.D.; Jack Boyles, M.D., Dayton; and Rep. Larry Christman, Dayton, during the Legislative Program. (3) Stephen P. Hogg, M.D., and Harry H. Fox, M.D., Cincinnati.

ROW SIX: (1) Dr. and Mrs. Benjamin H. Reed, Jr., Delta; C. Douglass Ford, M.D., and Roland A. Gandy, Jr., M.D., Toledo. (2) The Summit County contingent. (3) Richard E. Hartle, M.D., Lancaster, presents Clinical Investigation Bronze Award to Wei-Kuo Li, M.D., Dayton, for his exhibit "Ankle-Knee Synchronous in a New Endoskeletal Above-Knee Prosthetic Mechanism."

Photograph identification for page 474 *(left to right):*

ROW ONE: (1) Edward G. Kilroy, M.D.; John J. Gaughan, M.D.; and Theodore J. Castele, M.D., Cleveland. (2) John R. Beljan, M.D., Dean, Wright State University School of Medicine, accepts an AMA-ERF check from Philip B. Hardymon, M.D., Columbus, Chairman of the AMA-ERF Committee. (3) Harold F. Mills, M.D., Mansfield; A. Burney Huff, M.D., Wooster; and S. Baird Pfahl, M.D., Sandusky.

ROW TWO: OSMA Executive Director Hart F. Page addresses a reference committee. (2) William M. Wells, M.D., Newark, and Robert N. Smith, M.D., Toledo. (3) Wood carvings at the Art Show. (4) Dr. and Mrs. Albert May, Marion.

ROW THREE: (1) James A. Murray, M.D., Fostoria; Leonard K. Smith, M.D., Kenton; Dave Neilson, M.D., Waynesfield; James H. Steiner, M.D., West Liberty; and Paul E. Lyon, M.D., Marion. (3) OMPAC speaker Robert D. Novak, Washington, D.C.

ROW FOUR: (1) Robert E. Logsdon, M.D., Marion. (2) Past President Theodore L. Light, M.D., Dayton. (3) Carl A. Lincke, M.D., Carrolton; Thomas E. Fox, M.D., Mason; and Chairman Donavin A. Baumgartner, M.D., Cleveland, of Resolutions Committee No. 2.

ROW FIVE: (2) Stewart B. Dunsker, M.D., Cincinnati; Carl G. Thompson, Jr., M.D., Cincinnati; Robert E. Rinderknecht, M.D., Dover; Carl A. Lincke, M.D., Carrolton; and Elias Freeman, M.D., Cadiz. (3) Art Show Chairman Ludolph H. van der Hoeven, M.D., Dayton, presents an award.

ROW SIX: Felino Barnes, M.D.; Peggy Jeanne St. Clair, M.D.; and George P. Leicht, M.D., Cleveland, Chairman of the Committee on Nominations. (2) Herbert G. Magenheim, M.D.; Stewart B. Dunsker, M.D.; and Harold Pescovitz, M.D., Cincinnati. (3) James J. Thomas, M.D., Alliance; William Banfield, M.D., East Liverpool; Edward E. Grable, M.D., Canton; and J. James Anderson, M.D., Youngstown.





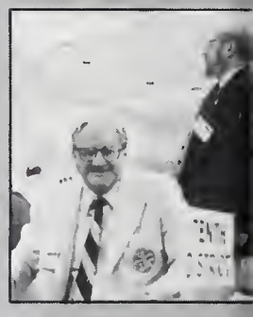










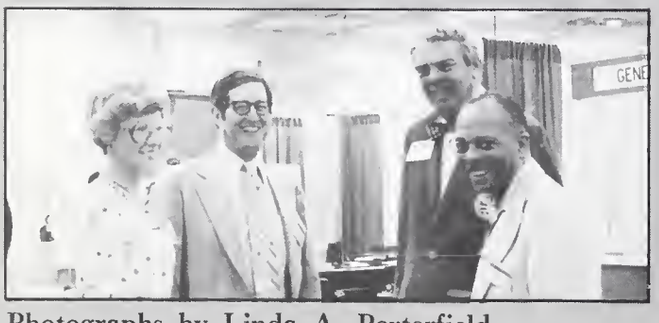
















Photographs by Linda A. Porterfield

(See page 455 for identification)

Proceedings of the OSMA House of Delegates Assembled at the 1978 Annual Meeting

Minutes of the First Session

The first session of the House of Delegates of the Ohio State Medical Association was convened at 7 PM, Sunday, May 7, 1978, at the Dayton Exhibition Center, Dayton, with President William M. Wells presiding.

The Invocation was offered by Rev. Raymond A. Roesch, S.M., Dayton.

Dr. Wells introduced Goodwin Berquist, Ph.D., Department of Communications, The Ohio State University, a parliamentarian retained in accordance with Resolution No. 1-76.

Dr. Herman I. Abromowitz, Dayton, President of the Montgomery County Medical Society, welcomed the delegates and guests to Dayton.

PRESIDENT'S ADDRESS

Mr. Page then introduced President William M. Wells, Newark, who delivered his Presidential Address.

After the Address, Dr. Wells received the applause of the House.

1977 MINUTES APPROVED

The minutes of the 1977 sessions of the House of Delegates, as published in the July 1977 and the February 1978 issues of *The Ohio State Medical Journal,* were approved by official action.

REPORT ON DELEGATES PRESENT

Dr. Richard L. Fulton, Columbus, Chairman of the Credentials Committee, reported that out of 180 delegates eligible to vote, 158 were seated. A number of alternate delegates, guests, officers of county medical societies, and executive secretaries were in attendance.

INTRODUCTION OF GUESTS

Dr. Wells introduced the following guests: Walter C. Buchsieb, D.D.S., Columbus, Vice President-Designee, Ohio Dental Association; Gertrude Torres, R.N., Dayton, President, Ohio Nurses Association; John F. Moore, D.V.M., Cincinnati, Ohio Veterinary Medical Association; Kenneth A. Frederick, M.D., Cincinnati, President, Ohio Academy of Family Physicians; Mrs. Ingrid May, Marion, President, and Mrs. Winnie Barrows, Cincinnati, President-Elect, Ohio State Medical Association Auxiliary.

INTRODUCTION OF OSMA PAST PRESIDENTS

The following Past Presidents of the Association were introduced: Dr. Carl A. Lincke, Carrollton; Dr. Charles L. Hudson, Cleveland; Dr. Richard L. Meiling, Columbus; Dr. Frank H. Mayfield, Cincinnati; Dr. George W. Petznick, Cleveland; Dr. Robert E. Howard, Cincinnati; Dr. Theodore L. Light, Dayton; Dr. Robert N. Smith, Toledo; Dr. Richard L. Fulton, Columbus; Dr. P. John Robechek, Cleveland; Dr. Oscar W. Clarke, Gallipolis; and Dr. George N. Bates, Toledo.

INTRODUCTION OF PAST MEMBERS OF THE OSMA COUNCIL

Dr. Wells then introduced former members of the Council: Dr. Philip B. Hardymon, Columbus; Dr. Stephen P. Hogg, Cincinnati; Dr. James C. McLarnan, Mt. Vernon; Dr. Paul F. Orr, Perrysburg; and Dr. George J. Schroer, Ft. Loramie.

OTHER GUESTS INTRODUCED

Dr. Wells introduced the following: Dr. John H. Ackerman, Columbus, Director, Ohio Department of Health; Mr. Oren "Bud" Wright, Chicago, Illinois, Director, Department of Federation Communications of the AMA; and James E. Pohlman, Esq., Columbus, OSMA Legal Counsel.

REPORT OF OSMA AUXILIARY PRESIDENT

Mrs. Ingrid May, Marion, President of the Ohio State Medical Association Auxiliary, was escorted to the podium by Dr. C. Edward Pichette. She addressed the House of Delegates on activities of the Auxiliary during her term of office.

AMA-ERF CHECKS PRESENTED

Dr. Philip B. Hardymon, Columbus, Chairman of Ohio's Committee for the American Medical Association's

Education and Research Foundation (AMA-ERF) made the presentation of the AMA-ERF checks as follows:

* To Dr. Francis F. Silver, President of the Alumni Association, Case Western Reserve University School of Medicine, Cleveland: $7,984.39;

* To Dr. J. Hutchison Williams, Associate Dean for Student Affairs, The Ohio State University College of Medicine, Columbus: $17,465.41;

* To Dr. William A. Sodeman, representing the Medical College of Ohio at Toledo, Toledo: $5,478.01;

* To Dr. Robert S. Daniels, Dean, University of Cincinnati College of Medicine, Cincinnati: $14,213.38;

* To Dr. Robert A. Liebelt, Dean, Northeastern Ohio Universities College of Medicine, Kent: $3,907.09;

* To Dr. John R. Beljan, Dean, Wright State University School of Medicine, Dayton: $5,797.73.

Dr. Wells expressed thanks on behalf of the Association to Dr. Hardymon and to the OSMA Auxiliary.

PRESENTATION OF DISTINGUISHED SERVICE CITATION

Dr. Robert N. Smith, Toledo, was named the recipient of the 1978 Distinguished Service Citation. The Citation was read by Dr. George N. Bates. Dr. Smith expressed his thanks to the House.

CERTIFICATES OF APPRECIATION

Dr. George N. Bates, Toledo; Dr. Stephen P. Hogg, Cincinnati; and Dr. Robert E. Rinderknecht, Dover; received plaques in appreciation of their service to the Association as retiring members of the Council.

REFERENCE COMMITTEES APPOINTED

The following House of Delegates Reference Committee chairmen were appointed and introduced by the President:

Credentials of Delegates — Dr. Richard L. Fulton, Chairman, Franklin County; *Tellers and Judges of Election* — Dr. William B. Selnick, Chairman, Clermont County; *President's Address* — Dr. David A. Barr, Chairman, Allen County; *Resolutions Committee No. 1* — Dr. David J. Hickson, Chairman, Morrow County; *Resolutions Committee No. 2* — Dr. Donavin A. Baumgartner, Chairman, Cuyahoga County; *Resolutions Committee No. 3* — Dr. Stanley J. Lucas, Chairman, Hamilton County.

ELECTION OF COMMITTEE ON NOMINATIONS

The House of Delegates nominated and elected the following persons, one from each district, for the Committee on Nominations: *First District* — Dr. Robert S. Heidt, Hamilton County; *Second District* — Dr. Isador Miller, Champaign County; *Third District* — Dr. Joseph M. Oppenheim, Allen County; *Fourth District* — Dr. Roland A. Gandy, Jr., Lucas County; *Fifth District* — Dr. George P. Leicht, Cuyahoga County; *Sixth District* — Dr. J. James Anderson, Mahoning County; *Seventh District* — Dr. Lois R. Zimmerman, Belmont County; *Eighth District* — Dr. John P. Anderson, Jr., Licking County; *Ninth District* — Dr. Roger P. Daniels, Meigs County; *Tenth District* — Dr. Joseph A. Bonta, Franklin County; *Eleventh District* — Dr. Harold F. Mills, Richland County; and *Twelfth District* — Dr. W. Paul Kilway, Jr., Summit County.

Dr. Wells then announced that under the system of rotation approved by the House of Delegates in 1963, the chairman of the Committee this year would be the delegate from the Fifth District, Dr. George P. Leicht, Cuyahoga County.

INTRODUCTION OF RESOLUTIONS

Dr. Wells said that inasmuch as the resolutions had been printed and distributed prior to the meeting and the assignment of resolutions to the Resolutions Committees had also been presented in writing, the necessity to introduce them one by one would, without objection, be waived. No objection was voiced by the House.

Dr. Wells also announced that Resolutions 11-78 and 38-78 had been withdrawn by their sponsors.

REPORT OF THE COMMITTEE ON EMERGENCY RESOLUTIONS

The Committee on Emergency Resolutions, consisting of the chairmen of the three resolutions committees, met earlier on May 7 to consider six emergency resolutions.

Dr. David J. Hickson, Chairman, reported that the Committee had approved the introduction of the six resolutions. Thereupon, President Wells assigned numbers and referred the resolutions to committees, as follows:

Resolution No. 54-78, "Establishment of National PSRO Guidelines," to Committee No. 1; Resolution No. 55-78, "Funds for Defense," to Committee No. 1; Resolution No. 56-78, "Physicians Responding to Emergencies in Hospitals," to Committee No. 2; Resolution No. 57-78, "Continuation of General Practice Residencies," to Committee No. 3; Resolution No. 58-78, "Ohio Department of Public Welfare (Medicaid Division) Pre-Admission Review Forms," to Committee No. 3; and Resolution No. 59-78, "OMI Medical Necessity Program," to Committee No. 2.

The House voted to approve the report of the Committee on Emergency Resolutions.

SPECIAL RESOLUTION

Dr. Gaughan was introduced and read the following resolution entitled "Creating the Office of Honorary President of the Ohio State Medical Association":

WHEREAS, John H. Budd, M.D., is completing his term as President of the American Medical Association, and

WHEREAS, John Budd has served his profession and its organizations at a local, state and national level for more than a third of a century with great distinction and multiple honors, and

WHEREAS, he has given of his many talents and abilities totally and unselfishly, without thought of personal reward or self-aggrandizement, and

WHEREAS, Dr. Budd has rendered many distinguished services to the physicians of Ohio through his activities in the Ohio State Medical Association in various capacities as chairman of several standing and select committees, as chairman of committees of this House of Delegates, and as chairman of the Ohio Delegation to the American Medical Association, THEREFORE BE IT

RESOLVED, that this House of Delegates of the Ohio State Medical Association here assembled on this 7th of May, 1978, as a demonstration of the tremendous appreciation, gratitude and affection Ohio medicine holds for this great and compassionate physician, hereby establishes and names John H. Budd, M.D., to the office of

Honorary President
of the
Ohio State Medical Association

Dr. Gaughan moved the suspension of the rules and the adoption of the resolution. The rules were suspended by official action, and the resolution was seconded and adopted unanimously by a standing vote of the House.

HOUSE RECESSED

The House then recessed until the final session, 3:30 PM, Wednesday, May 10.

Minutes of the Second Session

The final business session of the House of Delegates convened at 3:30 PM, Wednesday, May 10, at the Dayton Exhibition Center, Dayton.

PRESENTATION OF ART SHOW AND PHOTOGRAPHY EXHIBIT AWARDS

Dr. Ludolph H. van der Hoeven, Dayton, Chairman of the Art Show, presented the awards to the 1978 winners. Dr. van der Hoeven was presented a certificate in appreciation for his service as chairman.

Dr. Harry K. Hines, Cincinnati, Chairman of *The Ohio State Medical Journal* Photographic Exhibit, made the presentation to the 1978 photography winners.

INTRODUCTION OF AMA PRESIDENT

Dr. Wells presented Dr. John H. Budd, AMA President and Honorary OSMA President. Dr. Budd thanked the House for the many honors he had received and then addressed the House in response to President Carter's remarks against the medical profession made on May 5, 1978.

REPORT OF CREDENTIALS COMMITTEE

Dr. Richard L. Fulton, Columbus, Chairman of the Committee on Credentials, reported that out of 180 delegates eligible to vote, 165 were seated.

ELECTION OF PRESIDENT-ELECT

Dr. Wells called for nominations for the office of President-Elect.

Dr. Tom F. Lewis, Columbus, placed in nomination Dr. Sol Maggied, West Jefferson, Madison County. The nomination was seconded by Dr. Robert J. Blough, Deshler.

Dr. Oscar W. Clarke, Gallipolis, placed in nomination Dr. Thomas W. Morgan, Gallipolis, Gallia County, Councilor of the Ninth District. The nomination was seconded by Dr. W. J. Lewis, Dayton.

There were no other nominations. Dr. Morgan was elected by a majority on the first ballot.

INTRODUCTION OF COMMITTEE ON SCIENTIFIC WORK CHAIRMAN

Dr. John E. Albers, Cincinnati, Chairman of the Committee on Scientific Work, introduced the following resolution of appreciation:

WHEREAS, The Annual Meeting of the Ohio State Medical Association has returned to Dayton after an absence of two score and more years. Now THEREFORE BE IT

RESOLVED, That this House of Delegates congratulates and expresses deep appreciation to the Montgomery County Medical Society, to its gracious president, Dr. Herman Abromowitz, to its officers, to its glee club, and to its staff, for their friendship, their hospitality, and for making us feel that we are sincerely welcomed to their medical community, and BE IT FURTHER

RESOLVED, That this House thanks the Convention Bureau, the staff of the Convention Center, The Wright State University faculty, dining room and its theater group, and the hotels, for their sincere efforts to please the members and guests attending this Convention.

The rules were suspended by official action and the resolution was seconded and unanimously passed.

Dr. Wells officially expressed the appreciation of the Ohio State Medical Association to Dr. Albers, Chairman, and to the Committee on Scientific Work for the excellence of the meeting.

REPORT OF NOMINATING COMMITTEE

Dr. George P. Leicht, Delegate, Cuyahoga County, Chairman of the Committee on Nominations, presented the report of the Nominating Committee as follows:

First District: As Councilor of the First District to succeed himself, the Committee placed in nomination Dr.

Stewart B. Dunsker, Cincinnati. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Dunsker was declared reelected Councilor of the First District for a term of two years, 1978-1979 and 1979-1980.

Third District: As Councilor of the Third District to succeed himself, the Committee placed in nomination Dr. Alford C. Diller, Van Wert. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Diller was declared reelected Councilor of the Third District for a term of two years, 1978-1979 and 1979-1980.

Fifth District: As Councilor of the Fifth District to succeed himself, the Committee placed in nomination Dr. Theodore J. Castele, Cleveland. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Castele was declared reelected Councilor of the Fifth District for a term of two years, 1978-1979 and 1979-1980.

Seventh District: As Councilor of the Seventh District to succeed Dr. Robert E. Rinderknecht, Dover, the Committee placed in nomination Dr. H. Judson Reamy, Dover. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Reamy was declared elected Councilor of the Seventh District for a term of two years, 1978-1979 and 1979-1980.

Ninth District: As Councilor of the Ninth District to succeed Dr. Thomas W. Morgan, Gallipolis, the Committee placed in nomination Dr. A. Burton Payne, Ironton. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Payne was declared elected Councilor of the Ninth District for a term of two years, 1978-1979 and 1979-1980.

Eleventh District: As Councilor of the Eleventh District to succeed himself, the Committee placed in nomination Dr. S. Baird Pfahl, Jr., Sandusky. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Pfahl was declared reelected Councilor of the Eleventh District for a term of two years, 1978-1979 and 1979-1980.

AMA Delegates: Dr. Leicht then presented the nominees for the office of Delegate to the American Medical Association for a term of two years beginning January 1, 1979: Doctors Thomas E. Fox, Mason; Richard L. Fulton, Columbus; Jerry L. Hammon, West Milton; H. William Porterfield, Columbus; Jack Schreiber, Canfield; and Robert N. Smith, Toledo. The nominations were duly seconded and there were no further nominations from the floor. Doctors Hammon, Porterfield, Schreiber, and Smith were reelected on the first ballot.

AMA Alternate Delegates: For Alternate Delegate for the remainder of the term of Dr. Dwight L. Becker, ending December 31, 1978, the Nominating Committee placed in nomination the names of Doctors Alford C. Diller, Van Wert; Stewart B. Dunsker, Cincinnati; and Edward G. Kilroy, Cleveland. The nominations were seconded and a ballot taken. Dr. Dunsker was elected on the first ballot to the unexpired portion of the term, beginning May 10, 1978 and ending December 31, 1978.

Dr. Leicht then presented the nominees for the office of AMA Alternate Delegate for a term of two years beginning January 1, 1979: Doctors Joseph A. Bonta, Columbus; Alford C. Diller, Van Wert; Stewart B. Dunsker, Cincinnati; Thomas E. Fox, Mason; B. Leslie Huffman, Maumee; Edward G. Kilroy, Cleveland; Sol Maggied, West Jefferson; C. Edward Pichette, Youngstown; and Robert G. Thomas, Elyria. The nominations were seconded and a ballot taken. After five ballots, the following were elected Alternate Delegates to the American Medical Association for a term of two years, beginning January 1, 1979: Doctors Diller, Dunsker, Huffman, and Thomas.

COMMITTEE ON PRESIDENT'S ADDRESS

Dr. Wells then called for the report of the Reference Committee on President's Address, which was presented by Dr. David A. Barr, Allen County, Chairman of the Committee. The report read as follows:

Doctor Wells summarizes his year as President of the Ohio State Medical Association by stating, "I believe we are making progress," and doing so by "working together—in unity." It was his feeling that if we have differences "let us reconcile them among ourselves by being objective, logical, realistic, and . . . flexible."

To demonstrate recent efforts along these lines, he used the formation of The Physicians Insurance Company of Ohio as an example. In addition he felt that we should extend support to our colleagues in Kentucky by helping them implement their own program. Dr. Wells reinforced the support of PICO's expansion into general liability insurance and the continued ownership of the Class B stock by OSMA.

Rising health care costs is another issue that must be solved by joint effort. We were reminded that "we are the ones, the only ones who can actually do something about health care costs — while at the same time maintaining the *high quality of medical care*—." In order to control rising health care costs, education of the general public and cost awareness in our offices and hospitals were recommended. "High quality medical care with its advanced technology is expensive" and the cost is escalated by general inflation, insurance programs, governmental interference, and staff salaries. The OSMA has established a Cost Effectiveness Committee within its own ranks and has initiated the "Ohio Voluntary Effort" Committee to pursue similar goals for the state of Ohio.

Another important issue facing Ohio physicians involves past, present, and future state and federal legislation. A plea for involvement of the individual physician was made and the Certificate of Need Bill was used as an example. With regard to state and federal legislation affecting medicine, the OSMA is attempting to keep its members informed. Dr. Wells felt so strongly about "unity" that he expressed his own personal views concerning the action of the House of Delegates in December 1977. He emphasized that we must work in conjunction with Congress, the media, and the community to improve the delivery of medical care and thus the *quality of life.*

The Committee wants to commend Dr. Wells for his untiring efforts on our behalf. Dr. Wells' message was best summarized in his closing statement that— we can't do it separately or alone, but it can be accomplished together.

On a motion made and seconded, the House of Delegates, by official action, approved the report of the Reference Committee on President's Address.

REPORT OF RESOLUTIONS COMMITTEE NO. 1

Dr. David J. Hickson, Morrow County, reported for Resolutions Committee No. 1, of which he was Chairman. The report is as follows:

Resolutions Committee No. 1 met and considered the resolutions which were assigned to it.

The Committee was presented with resolutions which dealt primarily with the operation of the Ohio State Medical Association and its House of Delegates and with related subjects. After much discussion, some of the resolutions were combined.

RESOLUTION NO. 1-78
Prior Review of Resolutions

Resolution No. 1-78 was considered in depth. The Committee felt the logistics were awkward and impractical and recommended the resolution be **NOT** adopted and, Mr. President, I so move.

By official action, the House voted to reject Resolution No. 1-78.

RESOLUTION NO. 2-78
Grass Roots Representation to AMA

The Committee next considered Resolution No. 2-78.

The Committee felt this resolution would produce a legislative body of unwieldy size and a $27,000 increase in expenses.

The Committee, therefore, recommended to the House that Resolution No. 2-78 be **NOT** adopted and, Mr. President, I so move.

By official action, the House voted to reject Resolution No. 2-78.

RESOLUTION NOS. 3- 8- 10- and 15-78
State of the State
Utilization of County Society Leadership by OSMA
OSMA Interim Meeting
Interim Sessions of OSMA House of Delegates

The Committee considered Resolution No. 3-78, entitled "State of the State," and by expansion of the discussion in Executive Session added consideration of Resolution No. 8-78, entitled "Utilization of County Society Leadership by OSMA"; Resolution No. 10-78, entitled "OSMA Interim Meeting"; and Resolution No. 15-78, entitled "Interim Sessions of OSMA House of Delegates."

Testimony revealed the fact that, in essence, all four of these resolutions dealt with improvement of communications between the OSMA membership at the grass-roots level and the Association. As a result of extensive discussion, it was decided to submit a substitute resolution as follows:

Substitute Resolution No. 3-78
Improved Communications Within the OSMA

WHEREAS, The pace of medical progress has been greatly accelerated in the past ten years, and

WHEREAS, The issues facing organized medicine are growing, both in number and complexity, and

WHEREAS, The American Medical Association has recognized this fact and now holds an interim session of its House of Delegates on an annual basis, and

WHEREAS, The proponents from the grass roots before the Committee strongly expressed the opinion that there be improved communication between OSMA and the county societies, THEREFORE, BE IT

RESOLVED, That in order to increase communication between the OSMA and the county medical societies, the county medical society presidents (or their designees), the society executives, the officers and Council of the OSMA and the chairman (or co-chairmen) of the AMA delegation be called into session at OSMA headquarters prior to the December meeting of the AMA House of Delegates, and BE IT FURTHER

RESOLVED, That at this meeting the county societies shall receive a report on the activities of the OSMA and the plans of the AMA delegation and that there shall be opportunity for the county societies to offer comments, support and constructive suggestions, and BE IT FURTHER

RESOLVED, That at the third annual meeting of this group a vote shall be taken to determine if these meetings have been worthwhile and should be continued or discontinued/ *THE RESULTS OF THE VOTE SHALL BE REPORTED TO THIS BODY FOR INFORMATION AND ACTION,* and BE IT FURTHER

RESOLVED, To further improve communications between the OSMA and the county societies it is suggested that one or more meetings be held annually in each Councilor District to include the councilor, members of the OSMA staff, and the OSMA delegate and alternate delegate to the AMA from that area of the state, *AND THE COUNTY MEDICAL SOCIETY OFFICERS* and the county society delegates *AND ALTERNATES* to the OSMA, in order to discuss matters of mutual concern.

The Committee recommends the adoption of Substitute Resolution No. 3-78 and I so move.

By official action, the House voted to amend Substitute Resolution No. 3-78 as indicated by the language stricken out and by the language added in italic letters and then adopted it, as amended.

RESOLUTION NO. 4-78
Automatic Termination of Membership

We then considered Resolution No. 4-78. The Committee amended this resolution as follows:

Amended Resolution No. 4-78

WHEREAS, OSMA Bylaws, Chapter 1, Section 5, Effect of Expiration, Revocation, or Termination of Certificate presently reads, "Membership in this Association of a member in active practice whose certificate to practice medicine and surgery has expired, has been revoked, or has been otherwise terminated, shall be cancelled automatically as of the effective date of such expiration, revocation or termination. The provisions of this Section 5 shall not apply to members who have retired from active practice," and

WHEREAS, Voluntary suspension of certificate by a physician is sometimes necessary in the Physicians Effectiveness Program, and continued membership in the state and county medical societies may be vitally important in the rehabilitation of the physician, and

WHEREAS, The Councils of the state and county medical societies have the basic responsibility of determining continued membership in the organizations and this responsibilty should not be automatically transferred to another organization, namely, the State Medical Board; THEREFORE, BE IT

RESOLVED, That Chapter I, Section 5, of the Bylaws of the Association be amended to provide as follows: "Membership in this Association of a member in active practice whose certificate to practice medicine and surgery has expired, has

been revoked, or has been otherwise terminated, shall be cancelled automatically as of the effective date of such expiration, revocation or termination. The provisions of this Section shall not apply to members who have retired from active practice or to members whose certificate has been voluntarily ~~suspended~~ *SURRENDERED* due to illness*,*, *OR TO MEMBERS WHOSE LICENSE HAS AUTOMATICALLY EXPIRED BECAUSE OF PROBLEMS OF COMMUNICATION.*"

The Committee recommends that Amended Resolution No. 4-78 be adopted and, Mr. President, I so move.

By official action, the House **voted to amend Amended Resolution No. 4-78 as indicated by the language stricken out and by the language added in italic letters and then adopted it, as amended.**

RESOLUTION NOS. 5 and 7-78
Composition of Resolutions Committees
Amendment to OSMA Bylaws, Resolutions Committee

The Committee then considered Resolution No. 5-78, "Composition of Resolutions Committees," and Resolution No. 7-78, "Amendment to OSMA Bylaws, Resolutions Committee."

After much discussion, the Committee felt that a change in procedure would considerably lengthen the duration of service of the members of the resolutions committees and could result in creating standing resolutions committees.

The Committee recommended that Resolution No. 5-78 be **NOT** adopted. Since Resolution No. 7-78 is dependent upon the adoption of Resolution No. 5-78, the Committee recommended further that Resolution No. 7-78 be **NOT** adopted, and, Mr. President, I so move.

By official action, the House **voted to reject Resolution No. 5-78 and Resolution No. 7-78.**

RESOLUTION NO. 6-78
Obtaining Lists from OSMA Staff

The Committee considered Resolution No. 6-78. Testimony revealed that a policy concerning such requests was adopted by the OSMA Council on February 11, 1978.

The objection to such mailing lists is that their production could lead to unwarranted usage. Council adopted a policy that when such a request is made, it must be accompanied by a signed agreement that the list will be used in connection with the activities and work of the Association— and that the materials are not to be made available in whole or in part to any other person, association, corporation, organization, for any other purpose, including but without limitation, advertisng, promotional and mailing service organizations.

The Committee concluded that the question is now moot and recommends that the resolution be **NOT** adopted and, Mr. President, I so move.

By official action, the House **voted to reject Resolution No. 6-78.**

RESOLUTION NO. 9-78
H.R. 1818

The Committee considered Resolution No. 9-78 which concerned itself with promulgation of the actions of the Special Session of the House of Delegates of the OSMA on December 18, 1977.

Testimony elicited the fact that this action has already been accomplished through three separate forms of communications and, therefore, is redundant and the Committee recommends that the resolution be **NOT** adopted. Mr. President, I so move.

By official action, the House **voted to reject Resolution No. 9-78.**

RESOLUTION NO. 12-78
Speaker and Vice Speaker of the House of Delegates

The Committee next considered Resolution No. 12-78.

The present organization of the House of Delegates and the proposed change— the addition of a speaker and vice speaker of the House of Delegates— are two distinct methods of operation, each of which appears to work well in different organizations within this state. This proposal has been previously considered by the House of Delegates as in Resolution No. 9-77.

The testimony before the Committee revealed no new arguments in favor of the proposed change of the House of Delegates.

The Committee felt there was insufficient testimony in support of a change in the present organization and, therefore, recommends that Resolution No. 12-78 be **NOT** adopted and, Mr. President, I so move.

By official action, the House **voted to reject Resolution No. 12-78.**

RESOLUTION NO. 13-78
AMA Opinion Poll

The Committee next considered Resolution No. 13-78.

Testimony revealed it is the present policy of the AMA to conduct opinion polls of its members, although there appeared to be a lack of knowledge among OSMA members of such polling activity. The Committee felt much greater publicity should be given to the AMA polls.

It was recommended by the Committee that Resolution No. 13-78 be **NOT** adopted and, Mr. President, I so move.

By official action, the House **voted to reject Resolution No. 13-78.**

RESOLUTION NO. 14-78
Special Meetings of the OSMA House of Delegates

The Committee then considered Resolution No. 14-78.

Testimony disclosed that the OSMA House of Delegates has recently made the requirements for calling a special meeting less stringent in order to make the organization more responsive to the entire membership and this resolution would reverse this prior action by the House.

It was, therefore, recommended by the Committee that Resolution No. 14-78 be **NOT** adopted and, Mr. President, I so move.

By official action, the House **voted to reject Resolution No. 14-78.**

RESOLUTION NO. 16-78
OSMA Dues Increase

Resolution No. 16-78 was then considered. Testimony established the fact that the raise in dues essentially maintains the *status quo* in light of recent inflationary trends and is in line with sound fiscal policy for the Association.

Therefore, the Committee recommends the adoption of Resolution No. 16-78 and, Mr. President, I so move.

The resolution reads as follows:

WHEREAS, The OSMA income will be insufficient to support the demand made upon the Association during the forthcoming fiscal year; and

WHEREAS, The Ohio State Medical Association ranks 47th in the 50 State Medical Societies with regard to the amount of dues assessed by its governing body; THEREFORE BE IT

RESOLVED, That the dues of the Ohio State Medical Association be raised to $170 beginning with the 1979 dues year, THEREFORE BE IT FURTHER

RESOLVED, That dues for life membership be raised to $3,000.

By official action, the House **voted to adopt Resolution No. 16-78.**

RESOLUTION NOS. 17 and 55-78
Funds for Defense

The Committee then considered Resolutions No. 17- and 55-78. It was considered one of the most important matters to come before the Committee and, in order to expedite the establishment of this fund and at the same time protect the tax-exempt status of the OSMA, the Committee offers Substitute Resolution No. 17-78 which combines the best features of both. The substitute resolution reads as follows:

Substitute Resolution No. 17-78

WHEREAS, There has developed recently in our country much litigation involving various elements of organized medicine including individuals, hospital medical staffs, county medical societies, state medical societies, specialty medical societies and national medical societies, and

WHEREAS, Such litigation often raises serious constitutional and other legal issues affecting the rights of physicians, their ethical standards and their practice of medicine, and

WHEREAS, The cost of obtaining the legal services needed to represent fully the physicians' interests in such litigation may not be feasible for an individual or a group of individual physicians to bear, and

WHEREAS, It is in the best interests of all physicians to be represented fully in litigation in which issues of common concern to the medical profession are raised and decided, NOW, THEREFORE, BE IT

RESOLVED, That the President appoint an *Ad Hoc* Legal Assistance Committee to investigate methods for providing legal assistance to members in matters and litigation involving issues of common interest and concern to the membership giving due consideration to the scope of such legal assistance, the manner for determining which members shall receive legal assistance, the alternate methods for delivering such legal assistance, their costs and methods of funding and the effect, if any, of such legal assistance upon the Association's tax status, and to consider the possibility of inclusion of other professional groups, and, BE IT FURTHER

RESOLVED, That if the establishment of a legal assistance program is deemed feasible by the *Ad Hoc* Legal Assistance Committee, the Committee shall report its recommendations to the Council *WITHIN 90 DAYS* for approval and implementation and, BE IT FURTHER

RESOLVED, That the Ohio delegation to the American Medical Association introduce a similar resolution applicable to this issue at the national level.

The Committee recommends that this Substitute Resolution No. 17-78 be adopted and, Mr. President, I so move.

By official action, the House **voted to amend Substitute Resolution No. 17-78 as indicated by the language added in italic letters and then adopted it, as amended.**

RESOLUTION NO. 18-78
OSMA Election Rules

The Committee then considered Resolution No. 18-78. There was no testimony in favor of the adoption of this resolution in the open hearings and its adoption was considered by this Committee not to be in the best interests of the OSMA.

Therefore, it is recommended by the Committee that the resolution be **NOT** adopted and, Mr. President, I so move.

By official action, the House **voted to reject Resolution No. 18-78.**

RESOLUTION NO. 54-78
Establishment of National PSRO Council Guidelines

The Committee considered Resolution No. 54-78. Because the Ohio State Medical Association does not participate directly in PSRO, which involves direct relationships between local PSROs and individual hospital staffs, and in light of testimony suggesting certain changes, Resolution No. 54-78 is amended to read as follows:

Amended Resolution No. 54-78

WHEREAS, The National PSRO Council has created Guidelines relative to the 11 most commonly performed operative procedures, and

WHEREAS, The plans presently call for expansion of these Guidelines to include criteria for more than a hundred additional surgical procedures by January 1, 1979, and

WHEREAS, These Guidelines would interfere with a physician's freedom to exercise his expertise in treating patients, and

WHEREAS, The National PSRO Council has indicated that such Guidelines are not to be modified by local PSROs, a position which is in violation of the intent of the original PSRO laws, THEREFORE, BE IT

RESOLVED, That the OSMA vigorously oppose the establishment ~~not only~~ of ~~these~~ national PSRO criteria ~~for surgical procedures but also of all national PSRO criteria~~ *WHEN OFFERED WITHOUT A PROVISION FOR LOCAL AMENDMENT OR MODIFICATION AS NOW MANDATED BY PL 92-603* and, BE IT FURTHER

RESOLVED, That the OSMA Delegates to the AMA bring such action by this House to the attention of the AMA House of Delegates and urge that such policies be adopted by the AMA.

The Committee recommends the adoption of Amended Resolution No. 54-78 and, Mr. President, I so move.

By official action, the House **voted to amend Amended Resolution No. 54-78 as indicated by the language stricken out and by the language added in italic letters and then adopted it, as amended.**

The report of Resolutions Committee No. 1, as a whole, as amended, was approved by the House.

REPORT OF RESOLUTIONS COMMITTEE NO. 2

Dr. Donavin A. Baumgartner, Cuyahoga County, reported for Resolutions Committee No. 2, of which he was Chairman. The report is as follows:

Resolutions Committee No. 2 met on Monday, May 8, 1978, and heard testimony relating to the 19 resolutions which were assigned to this Committee.

RESOLUTION NO. 19-78
MSMS vs. BC/BS

The first resolution to be considered is Resolution No. 19-78 dealing with the problem between Blue Cross/Blue Shield of Michigan and the Michigan State Medical Society concerning discrimination between participating and non-participating physicians. Testimony was in support of the position of the Michigan State Medical Society. The Committee also recognized that this issue has been dealt with at the AMA level with the adoption of Resolution 64 (I-77) by the AMA House of Delegates and, therefore, recommends adoption of Amended Resolution No. 19-78.

Amended Resolution No. 19-78

WHEREAS, Blue Cross/Blue Shield of Michigan has moved to limit health care payments to certain participating physicians and to deny payment to other qualified physicians and,

WHEREAS, This insurance infringes upon the patient's right of freedom of choice of physicians and discriminates against some physicians, THEREFORE, BE IT

RESOLVED, That the OSMA House of Delegates confirm and adopt AMA Resolution 64 (I-77) which states, "That the American Medical Association oppose third-party differentiation between covered services provided by participating and non-participating physicians as discriminatory against

the physician who does not have a separate contractural relationship with the carrier and inhibiting the patient's free choice of physician" and, BE IT FURTHER

RESOLVED, That the Ohio State Medical Association notify the Michigan State Medical Society of our strong support and of the adoption of this resolution and, BE IT FURTHER

RESOLVED, That the Board of Trustees of the American Medical Association be notified of the adoption of this resolution.

Mr. President, I move the adoption of Amended Resolution No. 19-78.

By official action, the House **voted to adopt Amended Resolution No. 19-78.**

RESOLUTION NO. 20-78
PICO

The Committee next considered Resolution No. 20-78 and heard extensive testimony on both sides of this issue. It was felt by the Committee that it would not be wise at this time for the Ohio State Medical Association to divest itself of the Class B stock of PICO and, therefore, the Committee recommends that Resolution No. 20-78 be **NOT** adopted and, Mr. President, I so move.

By official action, the House **voted to reject Resolution No. 20-78.**

RESOLUTION NO. 21-78
Accountability

Resolution No. 21-78, expressing concerns over the accountability of the Ohio Delegation to the AMA, was considered next. The Committee felt that the first RESOLVED was in the interest of the OSMA Delegates and Members with appropriate clarification, but that the second RESOLVED would be unworkable at the AMA level at this time. The Committee, therefore, recommends adoption of the following amended resolution and, Mr. President, I so move.

Amended Resolution No. 21-78

WHEREAS, The voting record of Ohio delegates at AMA meetings is seldom known and never published, and

WHEREAS, This lack of accountability makes it possible for delegates to be more influenced by political pressures than by the wishes of their constituency, the practicing physician, THEREFORE BE IT

RESOLVED, The voting record of the Ohio Delegation to the AMA on final action on issues ~~should~~ be recorded and published in *The Ohio State Medical Journal*, and BE IT FURTHER

RESOLVED, *THAT THE USEFULNESS OF THIS MECHANISM BE RE-EVALUATED AT THE NEXT ANNUAL SESSION OF THIS HOUSE FOR RE-AFFIRMATION OF THIS PROCESS OF ACCOUNTABILITY.*

By official action, the House **voted to amend Amended Resolution No. 21-78 as indicated by the language stricken out and by the language added in italic letters, and then voted to refer the Amended Resolution to an Ad Hoc committee to be appointed by the President.**

RESOLUTION NO. 22-78
Confidentiality

The next resolution considered was Resolution No. 22-78. The Committee felt that this resolution is a reaffirmation of a long-standing position on the part of the Ohio State Medical Association and, accordingly, recommends adoption and, Mr. President, I so move.

The resolution reads as follows:

WHEREAS, The demands of persons and agencies not directly involved with the care of patients have increasingly violated the confidentiality of patients' records and interaction with his physician, often without his knowledge; and

WHEREAS, Such violations are a serious breakdown in the treatment plan, especially in psychiatry; THEREFORE, BE IT

RESOLVED, That confidentiality in all of medicine, but especially in psychiatric practice, shall be firmly reasserted *sine qua non* in the care of patients, and further that we strongly reaffirm the right of the patient to decide who shall view and have access to his records.

By official action, the House **voted to adopt Resolution No. 22-78.**

RESOLUTION NO. 23-78
Insurance Coverage for Psychiatric Patients

Resolution No. 23-78, concerning insurance coverage for psychiatric patients, was then discussed. It was noted that AMA Resolution 50 (I-77) dealing with the problem was referred to the Board of Trustees of the AMA for consideration and recommendations. The Committee, therefore, feels that appropriate action has already been taken and recommends that Resolution No. 23-78 be **NOT** adopted and, Mr. President, I so move.

By official action, the House **voted to reject Resolution No. 23-78.**

RESOLUTION NO. 24-78
Collateral Source

The next resolution was Resolution No. 24-78 which requests the Ohio State Medical Association to draft and to propose legislation to eliminate collateral source payments of all kinds from court judgments or awards. The Committee recognizes this as a reaffirmation and logical extension of Resolution No. 30-77 adopted last year by this body in support of the recommendations of the Governor's Advisory Commission and, therefore, recommends the adoption of Resolution No. 24-78 and, Mr. President, I so move.

The resolution reads as follows:

WHEREAS, Collateral source payments now often account for a major portion of expenses claimed by an injured individual; and

WHEREAS, Utilizing such payments in the total expenses in determining awards result in an unjustified windfall for such an individual and increase the costs to the general public through increased premiums for the collateral source insurance; and

WHEREAS, H.B. 682 has already eliminated collateral sources paid by governmental agencies; and

WHEREAS, The elimination of all collateral source payments from judgments or awards has been recommended by the Governor's Advisory Commission, the HEW report on Medical Malpractice and by the American Bar Association's Committee on Malpractice; THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association draft and propose legislation to provide that collateral source payments of any kind shall be deducted from any judgment or award and include a provision prohibiting the payor of any collateral source benefits from recovering the amount of collateral source payment from either the defendant or the defendant's insurer; and BE IT FURTHER

RESOLVED, That such legislation shall be introduced at a time when the Ohio State Medical Association Task Force on Professional Liability and/or the Council of OSMA feels it is most advantageous.

By official action, the House **voted to adopt Resolution No. 24-78.**

RESOLUTION NO. 25-78
Tort Reform

The next resolution considered was Resolution No. 25-78, listing several major tort reforms that the Committee felt would be of benefit to all Ohio citizens and would be supported in conjunction with other interested groups and not merely by action of the Ohio State Medical Association alone. The Committee therefore recommends adoption of Resolution No. 25-78 and, Mr. President, I so move.

The resolution reads as follows:

WHEREAS, The number of unjustified malpractice suits continues to be a severe problem; and

WHEREAS, Such unjustified suits are not limited to medical malpractice; THEREFORE, BE IT

RESOLVED, That the OSMA join with others in drafting and proposing legislation to provide the following:

(1) Require mandatory notification in writing of all parties of intent to sue at least ninety days prior to the actual filing, with provisions to indicate that such would specifically not further toll the statute of limitations set forth in Section 2305.11A of the Revised Code. *(NOTE:* At least six states already have adopted similar rules. This has been recommended by the American Bar Association's Committee on Malpractice 1977. The American Trial Lawyers Association has recorded "no objection" to such provision.)

(2) Amend the Ohio Revised Code to include a section similar to Section 41 of the Civil Practice Act of the State of Illinois stating: "Allegations and denials, made without reasonable cause and found to be untrue, shall subject the party pleading them to the payment of reasonable expenses actually incurred by the other party by reason of the untrue pleading, together with a reasonable attorney's fee, to be summarily taxed by the court upon motion made within thirty days of the judgment or dismissal."

(3) Alter present law to change the unfavorable climate now existing in Ohio obstructing justifiable countersuit activity by the following:

(a) Provide that actions for malicious prosecution may be predicated upon loss of reputation, legal and other expenses incurred in defending an action brought without reasonable grounds and that it is not necessary that such action deprive the defendant of personal property or liberty as a predicate for an action for malicious prosecution.

(b) Provide that in any claim or counter-claim by a defendant charging that the original action is one maliciously brought, inquiry into whether there is reasonable cause for the action should include the extent to which the attorney investigated the case.

(c) Provide that evidence that an ordinary review of the records and other evidence would have shown that the defendant committed no act or failed to act in such a way as to contribute to the proximate cause of the incident which is the subject of the action, would be prima facie evidence of malicious prosecution; and BE IT FURTHER

RESOLVED, That such legislation shall be introduced at a time when the OSMA Task Force on Professional Liability and/or the Council of OSMA feels it is most advantageous.

By official action, the House **voted to adopt Resolution No. 25-78.**

RESOLUTION NO. 26-78
Counter Suits

Testimony was then heard on Resolution No. 26-78 which requests the Ohio State Medical Association to investigate the possibility of financial support for selected meritorious counter suits which would be to the benefit of all members of the OSMA. Since the resolution leaves the final decisions on all matters to the OSMA Task Force on Professional Liability and the OSMA Council, the Committee recommends the adoption of Resolution No. 26-78 and, Mr. President, I so move.

The resolution reads as follows:

WHEREAS, A successful malpractice counter suit in Ohio would be a benefit to all physicians in this state; and

WHEREAS, Such action can be both time consuming and expensive; and

WHEREAS, Most individual practicing physicians have insufficient funds to pursue counter suit without assistance; THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association Task Force on Professional Liability pursue the possibility of providing financial assistance in counter suit cases felt to be meritorious and worthy of pursuit by the Ohio State Medical Association legal counsel and the OSMA Task Force on Professional Liability.

By official action, the House **voted to adopt Resolution No. 26-78.**

RESOLUTION NO. 27-78
Prompt Payment of Insurance Claims

The Committee next considered Resolution No. 27-78 concerning prompt payment of insurance claims. A number of significant points were raised that were not felt to be clearly defined. The Committee recognizes the need to urge insurance companies to streamline their methods of processing claims so as to avoid embarrassment and economical harm to the patient. However, the Committee questions the advisability of pursuing legislative action on this matter and, therefore, recommends that Resolution No. 27-78 be **NOT** adopted and, Mr. President, I so move.

By official action, the House **voted to reject Resolution No. 27-78.**

RESOLUTION NO. 28-78
Amendments to H.B. 682

Testimony was next heard on Resolution No. 28-78 to amend H.B. 682. The subject is complex and modifications might well be required. It was suggested that some of the measures might be accomplished without legislation. Therefore, the Committee recommends adoption of the following amended resolution.

Amended Resolution No. 28-78

WHEREAS, H.B. 682 established a Stabilization Reserve Fund (SRF) at an arbitrary level separate from funds held by the Joint Underwriting Association (JUA); and

WHEREAS, The numbers of physicians and hospitals insured by the JUA has been decreasing and is expected to continue to decrease; and

WHEREAS, The SRF had funds now in excess of $20 million and

WHEREAS, Funds held by the JUA separate from the SRF and excluding funds held in reserve for pending claims are greater than $35 million; THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association take appropriate action to accomplish the following:

(1) Permit the JUA to transfer earned premiums into the SRF until the SRF reaches, but does not exceed, $40 million.

(2) Limit the amount of surcharge paid by an individual or organization insured to no more than three years' payments unless the SRF should fall below a level of $5 million, at which time the Commissioner of Insurance would have the option of reinstituting the surcharge.

(3) Provide that the present SRF and all excess premiums held by the JUA be kept separate from any other funds that might be established for non-medical groups covered by the JUA.

(4) In the event that the JUA should cease to provide professional medical liability insurance, further define the manner in which the SRF and excess premiums above and

beyond those funds set aside for pending or future claims will be returned on a *pro rata* basis to all those individuals or, organizations who paid in, or distribution otherwise consistent with the interests of the individual physician and the medical profession, and BE IT FURTHER

RESOLVED, That such action shall be initiated at a time when the OSMA Task Force on Professional Liability and/or the Council of OSMA feels it is most advantageous.

Mr. President, I move the adoption of Amended Resolution No. 28-78.

By official action, the House **voted to adopt Amended Resolution No. 28-78.**

RESOLUTION NOS. 29- and 34-78
OMI Letters
Ohio Medical Indemnity Fair Fee Support Program

The Committee next considered Resolution No. 29-78 and Resolution No. 34-78 together as addressing the same issue. Lengthy testimony and discussion was heard. After due consideration, the Committee recommends the adoption of Substitute Resolution No. 29-78 and, Mr. President, I so move.

Substitute Resolution No. 29-78
Letters by Third-Party Carriers

WHEREAS, All insurers are reportedly under pressure from government agencies to reduce the amounts paid to physicians for services rendered, and

WHEREAS, Ohio Medical Indemnity and other third-party carriers have responded by writing letters to patients with UCR contracts in which they offer to intercede on the side of the patient in payment disputes, and

WHEREAS, These letters derogatorily imply overcharge by the physician and are therefore damaging to the patient-physician relationship, and

WHEREAS, The patient-physician relationship is one of verbal contract, and

WHEREAS, There is a wide variability of physicians' fees for categorically similar procedures based on difficulties encountered in each case, physicians' individual practice experience, geographical location and other factors; THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association advise its members that their fees should be discussed with their patients whenever possible before care is rendered in order to reach a prior agreement that will obviate the need for any third-party carrier to invoke patient support mechanisms, and BE IT FURTHER

RESOLVED, That OSMA request all third-party carriers to desist from sending letters to UCR insureds offering to intercede against physicians in payment disputes and, instead, to inform the patient as to the carrier's maximum amount of reimbursement to the patient for a given procedure.

By official action, the House **voted to adopt Substitute Resolution No. 29-78.**

RESOLUTION NOS. 30- and 31-78
PICO

Extensive discussion was heard on Resolution No. 30-78 and Resolution No. 31-78 which, being opposing points of view on the same subject, were considered together. The Committee, although recognizing that some controversy exists regarding diversification programs initiated by PICO, felt that there has been ample evidence to indicate that the great majority of OSMA members and PICO stockholders support the present activities and programs of PICO and, therefore, recommends adoption of the following amended resolution.

Amended Resolution No. 30-78

WHEREAS, The Ohio State Medical Association formed the Physicians Insurance Company of Ohio to provide for Association members a market for medical professional liability insurance at reasonable rates, and

WHEREAS, It is advisable for any insurance company to lessen the risk of catastrophic loss by a prudent distribution of premium volume in as many diverse lines of insurance as possible, thereby reducing the risk of weakening its financial base in the event of potential losses in the professional liability insurance area, and

WHEREAS, It is thus advisable that the Physicians Insurance Company of Ohio exercise prudent financial judgment in seeking to lessen the risk of catastrophic loss by the sale of other property and casualty coverages to physicians, while retaining the primary interest and effort in the provision of adequate medical professional liability coverage, and

WHEREAS, There is a need for a physician-oriented life insurance company for the purpose of providing not only the programs in life and disability insurance currently sponsored by the Ohio State Medical Association, but also for the purpose of providing various pension and profit sharing plans, and

WHEREAS, The Board of Directors of the Physicians Insurance Company of Ohio has shown sound judgment in working to maintain the Company's most important coverage, medical professional liability insurance, while attempting to satisfy Physicians Insurance Company of Ohio (PICO) shareholders and all OSMA members that PICO will remain a physician's insurance company, THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association House of Delegates support the present activities and programs of PICO in order that PICO may be financially sound and in a position to offer all present lines of insurance at the lowest possible rates in accordance with sound insurance practices.

Mr. President, I move the adoption of Amended Resolution No. 30-78.

By official action, the House **voted to adopt Amended Resolution No. 30-78.**

RESOLUTION NOS. 32- and 33-78
Cost Containment
Voluntary Cost Containment

The Committee considered Resolution No. 32-78 and Resolution No. 33-78 together as being essentially identical in content. Two separate identifiable areas of costs that are subject to potential reduction are: (1) those under the control of physicians in hospitals and (2) those mandated by law, government regulations and guidelines. It was also strongly felt that quality care must not be allowed to suffer in the name of cost control. The Committee recommends adoption of Substitute Resolution No. 32-78 and, Mr. President, I so move.

Substitute Resolution No. 32-78
Cost Containment

WHEREAS, A "Voluntary Cost Containment" program has been initiated by the American Hospital Association, the American Medical Association, and the Federation of American Hospitals through a "National Steering Committee" of the three organizations, and

WHEREAS, The Ohio State Medical Association has established a "Cost Effectiveness Committee" headed by S. Baird Pfahl, M.D., Sandusky, the OSMA Councilor from the 11th District, and

WHEREAS, The Ohio State Medical Association by action of the Council is joining with the Ohio Hospital Association, the Ohio Osteopathic Association, and other organizations to form an Ohio Steering Committee, patterned after the National Committee, and

WHEREAS, The American Medical Association has established an independent Commission on the Cost of Medical Care which was mandated to provide a comprehensive overview

(continued on page 469)


COLACE prevents hard, dry stools common to constipation . . . and does it without laxative stimulation. COLACE assists peristalsis by simply letting intestinal water permeate stools.
COLACE helps to prevent painful straining at stool—particularly important in patients with delicate anorectal disorders. Safe and non-habit forming . . . COLACE, the simple water way to ease constipation from infancy to old age.
Simple drops of water help make COLACE® the most widely used stool softener.
COLACE®
dioctyl sodium sulfosuccinate
Mead Johnson
PHARMACEUTICAL DIVISION



Does it influence your choice of a peripheral/cerebral vasodilator*?

- Vasodilan—compatible with coexisting diseases
- Vasodilan—compatible with concomitant therapy
- Vasodilan—compatible with your total regimen for vascular insufficiency

*Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily.

Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

U.S. Pat. No. 3,056,836

VASODILAN®

(ISOXSUPRINE HCl)

20-mg tablets

Mead Johnson PHARMACEUTICAL DIVISION

© 1978 MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA 47721 U.S.A. MJL7-4268

of health care costs and possible approaches to the problems; THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association continue and intensify its efforts through its established committees and through its association with others to promote effective voluntary health care cost containment in those areas under the control of these groups while not compromising quality of care, and BE IT FURTHER

RESOLVED, *THAT THE OHIO STATE MEDICAL ASSOCIATION URGE SIMILAR COMMITMENT TO COST CONTAINMENT BY GOVERNMENT WITHIN ALL HEALTH CARE FACILITIES OPERATED BY GOVERNMENTAL AGENCIES,* AND BE IT FURTHER

RESOLVED, *THAT THE OHIO STATE MEDICAL ASSOCIATION URGE THAT* **OTHER** *COST CONTROL MEASURES BY GOVERNMENT BE SPECIFICALLY LIMITED TO THOSE COSTS WHICH ARE DIRECTLY RELATED TO* **MEETING** *GOVERNMENT REGULATIONS, GUIDELINES, AND MANDATES,* AND BE IT FURTHER

RESOLVED, ~~That the Ohio State Medical Association urge cost-control measures by government be specifically limited to those costs which are directly related to government regulations, guidelines, and mandates, and BE IT FURTHER~~

RESOLVED, That this resolution be presented to the appropriate departments of the Ohio state government and carried to the AMA by the Ohio Delegation for implementation on a national level to be transmitted to the appropriate federal agencies.

By official action, the House voted to amend Substitute Resolution No. 32-78 as indicated by the language stricken out and by the language added in italic letters and then adopted it, as amended.

RESOLUTION NO. 35-78
Doctors of Osteopathy

After hearing testimony on Resolution No. 35-78, it was noted that the first RESOLVED has been dealt with appropriately by the Ohio State Medical Board and requires no further action. The question raised in the second RESOLVED was felt to be complex and to involve questions that could not be answered at this time. The Committee therefore recommends that the issue listed in the RESOLVED be referred to the Council of the Ohio State Medical Association for further investigation and consideration and, Mr. President, I so move.

The text of the resolution is as follows:

WHEREAS, Ohio law states that each physician licensed to practice medicine in the State of Ohio must obtain 150 hours of post-graduate education every three years in order to be relicensed; and

WHEREAS, This continuing medical education (CME) must be certified by the OSMA (for MDs) or the OOA (for DOs); and

WHEREAS, Some physicians who hold the DO degree are members of the OSMA and are obtaining the CME credit in OSMA-approved programs; and

WHEREAS, It is impossible under present law for these physicians to fulfill their CME requirements; and

WHEREAS, Physicians licensed to practice medicine in the State of Ohio take the same examination, and have the same rights and privileges whether the medical school from which they graduated conferred the MD or the DO degree; and

WHEREAS, Today, the graduates of Osteopathic and Allopathic medical schools in this country are in essence equal; and

WHEREAS, Graduates of foreign medical schools who have not received the MD degree are entitled to use the designation MD when they are licensed by the State of Ohio; and

WHEREAS, Medical school graduates who received the DO degree are welcomed into AMA-approved postgraduate programs and may be certified by most of the AMA specialty boards in this country; and

WHEREAS, Universities sponsoring AMA-approved postgraduate specialty programs may confer the MD degree upon DOs who have successfully completed such programs; and

WHEREAS, The public interest would be better served if the MD or the DO designation were related to the physician's postgraduate training and hospital affiliation rather than the medical school from which the physician graduated; THEREFORE, BE IT

RESOLVED, That all physicians licensed to practice medicine in the State of Ohio should be able to have their CME requirements certified by either the OSMA or the OOA regardless of whether they hold the MD or the DO degree; and BE IT FURTHER

RESOLVED, That physicians licensed to practice medicine in the State of Ohio who have successfully completed at least one year of postgraduate training in an AMA-approved program and who have staff privileges solely in AMA-approved hospitals should have the right to use the designation MD in place of DO in all of their activities and correspondence.

By official action, the House voted to refer Resolution 35-78 to the Council of the Ohio State Medical Association for further investigation and consideration of the second Resolved.

RESOLUTION NO. 56-78
Physicians Responding to Emergencies in Hospitals

The Committee then considered Resolution No. 56-78 and heard testimony relating to the various legal problems involved in obtaining any form of immunity and recognizes that the eventual wording of such changes would be determined by legal requirements. However, the Committee feels that pursuit of this measure would benefit all patients and is of sufficiently narrow scope as to afford substantial chance for public and legislative support. The Committee therefore recommends adoption of Amended Resolution No. 56-78 and, Mr. President, I so move.

Amended Resolution No. 56-78

WHEREAS, The Academy of Medicine of Cleveland was informed of three instances in which physicians in a hospital were sued for attempting to resuscitate a patient in cardiac arrest, and

WHEREAS, The Academy of Medicine of Cleveland was not aware of this situation until after the deadline for filing resolutions for the 1978 OSMA Annual Meeting, and

WHEREAS, The Good Samaritan Law (O.R.C. 2305.23) provides "No person shall be liable in civil damages for administering emergency care or treatment at the scene of an emergency outside of a hospital, doctor's office, or other place having proper medical equipment, for acts performed at the scene of such emergency, unless such acts constitute willful or wanton misconduct . . .", and

WHEREAS, The Good Samaritan Law does not afford protection to physicians in a hospital setting who respond to a "triple page" or "doctor heart" call, a page indicating that a patient is in need of immediate medical care, even when the responding physician is not the attending physician for that patient, and

WHEREAS, The absence of immunity from civil liability may deter some physicians from responding to emergency pages and thereby endanger the life of the patient in need of immediate attention; THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association take appropriate action to seek an amendment to the Good Samaritan Statute (O.R.C. 2305.23) or work to have introduced new legislation which will extend immunity

from civil liability to physicians who voluntarily respond to emergency situations in any location provided that the responding physician does not bill for his services. ~~and provided that the cause of action is not specifically related to the emergency treatment.~~

By official action, the House **voted to amend Amended Resolution No. 56-78 as indicated by the language stricken out, then adopted it, as amended.**

RESOLUTION NO. 59-78
OMI Medical Necessity Program

The Committee finally heard testimony on Resolution No. 59-78. The Committee recognizes the responsibility of physicians to periodically review procedures and methods of therapy to eliminate those no longer considered to be of substantial value. Testimony revealed that Ohio Medical Indemnity merely indicated that on the list published were those surgical and diagnostic procedures which would no longer be routinely subject to reimbursement but would be considered on an individual basis. This Committee therefore felt that this resolution was not entirely based on accurate information and recommends that Resolution No. 59-78 be NOT adopted and, Mr. President, I so move.

By official action, the House **voted to reject Resolution No. 59-78.**

The report of Resolutions Committee No. 2, as a whole, as amended, was approved by the House.

REPORT OF RESOLUTIONS COMMITTEE NO. 3

Dr. Stanley J. Lucas, Hamilton County, reported for Resolutions Committee No. 3, of which he was Chairman. The report is as follows:

It is with a great deal of pleasure that I present this report for Reference Committee No. 3.

RESOLUTION NOS. 36- and 48-78
Contraceptive and Prenatal Services for Minors
Contraceptive Services for Minors

Resolution Nos. 36-78 and 48-78 were discussed together for they pertain to the same subject.

A great deal of time was taken in hearing testimony and discussing the issue. The magnitude of the medical and social problem warrants further action by the Ohio State Medical Association House of Delegates. Therefore, the following substitute resolution is submitted by the Committee:

Substitute Resolution No. 36-78

WHEREAS, Five years ago the Ohio State Medical Association House of Delegates adopted Resolution 10-73 which called for OSMA to introduce state legislation "permitting Ohio physicians to treat minors without parental consent in the following respects:

(1) To counsel about, as well as diagnose and treat venereal disease

(2) To counsel about and prescribe methods for contraception

(3) To medically manage pregnancy, excluding abortion," and

WHEREAS, The increasing frequency of pregnancy in minors is a source of national concern; and

WHEREAS, Means must be found to prevent medical and social problems that result from sexual activities and unwanted pregnancies in minors; THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association again propose state legislation permitting Ohio physicians, according to their own conscience, to counsel and prescribe methods for contraception to minors and to provide medical management of pregnancy of minors, excluding abortion, at the request of the minor.

Mr. President, I move the adoption of Substitute Resolution No. 36-78 in place of Resolution Nos. 36-78 and 48-78.

By official action, the House **voted to adopt Substitute Resolution No. 36-78.**

RESOLUTION NOS. 37- and 53-78
Proposed New Code of Medical Ethics
Principles of Medical Ethics

Resolution Nos. 37-78 and 53-78 relate to the subject of the proposed change in the Principles of Medical Ethics of the American Medical Association. The Committee recognized the immediate need of the American Medical Association to adopt a revised code of ethics which is in more accord with today's practice of medicine. The American Medical Association House of Delegates must accept or reject without modification the report of the AMA Judicial Council regarding the Principles of Medical Ethics according to the Procedures of the House of Delegates for the American Medical Association. Therefore, the following substitute resolution is submitted:

Substitute Resolution No. 37-78

WHEREAS, The Judicial Council of the American Medical Association has reviewed and has proposed revised Principles of Medical Ethics; and

WHEREAS, State and County Medical Societies have been given the opportunity to review and comment on these Principles; THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association House of Delegates endorse the proposed changes to the American Medical Association Principles of Medical Ethics as presented in Report: A (I-77) of the Judicial Council to the American Medical Association House of Delegates.

Mr. President, I move the adoption of Substitute Resolution No. 37-78 in place of Resolution Nos. 37-78 and 53-78.

By official action, the House **voted to adopt Substitute Resolution No. 37-78.**

RESOLUTION NO. 39-78
Public Understanding

It is the feeling of the Committee that there are now many new and innovative public relations programs of the Ohio State Medical Association which include publication of *Synergy,* regular releases to the press, and radio and television programming. All enhance the positive image of the physician. To embark on an additional program that can be quite costly and may be interpreted as derogatory to other providers of health care is considered inappropriate.

Mr. President, I move that Resolution No. 39-78 be **NOT** adopted.

By official action, the House **voted to reject Resolution 39-78.**

RESOLUTION NO. 40-78
Task Force to Study a State and Federal Tax Credit Reimbursement Plan

Although we are aware of the frustration of physicians in dealing with reimbursement procedures of the Ohio Department of Public Welfare, the Committee felt that the proposed resolution does not provide a feasible solution to the problem. The resolution also does not address itself to the issue of the complicated paper work necessary in Welfare reimbursement.

Mr. President, I move that Resolution No. 40-78 be **NOT** adopted.

The text of the resolution reads as follows:

WHEREAS, There is wide-spread dissatisfaction on the part of Ohio physicians with the system of reimbursement by the Ohio Department of Public Welfare, and

WHEREAS, The reimbursement procedure is cumbersome, unwieldy and fraught with error, and

WHEREAS, The system results in partial payment at best which may disenfranchise the patient's total medical care; THEREFORE, BE IT

RESOLVED, That a Task Force be created to study a state and federal tax credit reimbursement plan as an option in lieu of payment for professional services rendered, and BE IT FURTHER

RESOLVED, That representation of the Miami County Legislative Committee be included in this Task Force.

By official action, the House voted to refer Resolution No. 40-78 to the Council of the Ohio State Medical Association.

RESOLUTION NO. 41-78
Sale of Cigarettes by Hospitals

The Committee felt a need for physician commitment in the area of community education and leadership regarding the hazards of smoking. Therefore, the Committee submits Amended Resolution No. 41-78:

Amended Resolution No. 41-78

WHEREAS, In recent years there has been an increased emphasis on the problems associated with smoking; and

WHEREAS, Medical evidence has continued to accumulate emphasizing this point; and

WHEREAS, One of the primary functions of the medical and health-related fields is the preservation of health; and

WHEREAS, The lay community looks to the medical profession for guidance in health matters; and

WHEREAS, An inconsistency exists between the medical profession warning of the hazards of smoking and the continued sale of cigarettes and related smoking materials to the public by the profession's prime institution, the hospital; THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association strongly urge hospitals and related health facilities, both private and public, to discontinue the sale of such products on their grounds.

Mr. President, I move the adoption of Amended Resolution No. 41-78.

By official action, the House voted to adopt Amended Resolution No. 41-78.

RESOLUTION NOS. 42- and 52-78
Health Planning Guidelines
Health Planning Is a Community Right

Resolution Nos. 42-78 and 52-78 were discussed together. Both relate to health planning. The Committee submits the following Substitute Resolution No. 42-78:

Substitute Resolution No. 42-78

WHEREAS, Public Law 93-641 in Title XV — Section 1501 requires the Secretary of Health, Education and Welfare to issue guidelines concerning national health planning policy; and

WHEREAS, These guidelines will have a major impact on the availability of medical care for the patients residing in each Health Service Area; THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association work with component County Medical Societies to develop a mechanism for collection and interchange of health planning information; and BE IT FURTHER

RESOLVED, That the physicians of Ohio be encouraged to use such data to evaluate and influence federal health planning guidelines, including Health System Plans and Annual Implementation Plans, in order to assure the quality of medical care for the people of Ohio; and BE IT FURTHER

RESOLVED, That the Association herewith rededicates its commitment to the principle that the responsible residents of local areas have the right to determine their own planning standards and needs.

Mr. President, I move the adoption of Substitute Resolution No. 42-78 in place of Resolution Nos. 42-78 and 52-78.

By official action, the House voted to adopt Substitute Resolution No. 42-78.

RESOLUTION NOS. 43- and 51-78
Certificate of Need
Certificate of Need Denies Local Health Care Rights

Resolution Nos. 43-78 and 51-78 were discussed together. Although the Ohio State Medical Association has been active in opposition to the application of Certificate of Need legislation to physicians' offices, the Committee felt it appropriate to have the House of Delegates officially endorse this position for emphasis. We, therefore, propose the following Substitute Resolution:

Substitute Resolution No. 43-78

WHEREAS, Public Law 93-641, the National Health Planning and Resources Development Act, requires that all states enact Certificate of Need legislation by 1980 or be confronted with the loss of a substantial amount of federal health care funds; and

WHEREAS, Concern has been expressed that Certificate of Need has not been proven to be cost effective; and

WHEREAS, Public Law 93-641 does not apply to the private physician's office or medical equipment; THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association continue to oppose efforts at the state and federal levels to apply Certificate of Need authority to the private physician's office.

Mr. President, I move the adoption of Substitute Resolution No. 43-78 in place of Resolution Nos. 43-78 and 51-78.

By official action, the House voted to adopt Substitute Resolution No. 43-78.

RESOLUTION NO. 44-78
Rights of Lay Boards of Trustees to Mandate Policy to Medical Staffs

After deliberation Amended Resolution No. 44-78 is submitted:

Amended Resolution No. 44-78

WHEREAS, There are situations where hospital boards of trustees are unilaterally mandating policies which in effect alter previously adopted medical staff bylaws; THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association support the right of all medical staffs to conduct the practice of medicine in all facilities according to the rules and regulations governing the staffs as set forth in the bylaws and regulations drawn up and approved by both the medical staffs and the governing body of the facilities; and BE IT FURTHER

RESOLVED, That the Ohio State Medical Association oppose any unilateral action of hospital boards of trustees that alters or by-passes previously adopted regulations of medical staff bylaws; and BE IT FURTHER

RESOLVED, That this resolution be forwarded to the House of Delegates of the American Medical Association for their consideration and action.

Mr. President, I move adoption of Amended Resolution No. 44-78.

By official action, the House **voted to adopt Amended Resolution No. 44-78.**

RESOLUTION NO. 45-78
Community Mental Health Centers

The Committee supports the spirit of the resolution but recognized the resolve was inaccurate in relationship to Amended Resolution 51 passed by the House of Delegates of the American Medical Association at the Interim 1977 Session. We propose the following Amended Resolution No. 45-78 endorsing the position taken by the American Medical Association:

Amended Resolution No. 45-78

WHEREAS, Psychiatrists and other physicians in Ohio have been keenly disappointed in the direction taken in recent years by the Community Mental Health Centers (CMHC); and

WHEREAS, Resolution 51 introduced in the Interim 1977 Session of the House of Delegates of the American Medical Association accurately expresses the concerns of psychiatrists; THEREFORE, BE IT

RESOLVED, That the House of Delegates of the Ohio State Medical Association endorse the request of the American Medical Association to study the feasibility of examining and evaluating the effectiveness of Community Mental Health Centers and to report their findings to the House of Delegates of the American Medical Association.

Mr. President, I move adoption of Amended Resolution No. 45-78.

By official action, the House **voted to adopt Amended Resolution No. 45-78.**

RESOLUTION NO. 46-78
Definition of Psychosis and Mental Deficiency

Due to the lack of testimony for this resolution, the Committee believes that this resolution should not be adopted. Furthermore, the Committee felt the subject would be more appropriately addressed by the Ohio Psychiatric Association. If the subject is reintroduced to the Ohio State Medical Association at a later date, a new resolution should include evaluation of the extent of the problem with detailed definition of terms.

Mr. President, I move Resolution No. 46-78 be **NOT** adopted.

By official action, the House **voted to reject Resolution No. 46-78.**

RESOLUTION NO. 47-78
Guidelines of Medical Staff Bylaws

In reviewing this resolution, the Committee concluded that there are appropriate and sufficient guidelines developed by the Joint Commission for Accreditation of Hospitals for the adoption and amendment of medical staff bylaws. According to legal counsel, the development and adoption of guidelines by a physicians' organization in a concerted manner could expose the organization to legal liability.

Therefore, Mr. President, I move that Resolution No. 47-78 be **NOT** adopted.

By official action, the House **voted to reject Resolution No. 47-78.**

RESOLUTION NO. 49-78
Supervision of Physician Extenders

Much time was spent on this resolution. The more the Committee discussed the issue, the more apparent it became that there is a major problem in defining who is and who is not a physician extender. The myriad of personnel affected includes secretaries, nurses, laboratory assistants, nurse clinicians, anesthesiologist assistants, paramedics, etc.

The Committee recommends the following substitute resolution:

Substitute Resolution No. 49-78

WHEREAS, The involvement of physicians in the setting of standards of care in all of the paraprofessional areas is important; and

WHEREAS, The definition of physician extenders is unclear; and

WHEREAS, This problem needs study and must be addressed; THEREFORE, BE IT

RESOLVED, That the President of the Ohio State Medical Association refer the issue, including definition and supervision of physician extenders, to the Health Manpower Committee for study and report back to the House of Delegates of the OSMA in 1979.

Mr. President, I move adoption of Substitute Resolution No. 49-78.

By official action, the House **voted to adopt Substitute Resolution No. 49-78.**

RESOLUTION NO. 50-78
To Create an Ad-Hoc Committee on Foreign Medical Graduates, Cosponsor with a Medical School or Any Other School, Courses in the Basic Sciences and English for Foreign Medical Graduates

The American Medical Association in July 1977 established an office for the foreign medical graduate. In December 1977, the Interim House of Delegates of the American Medical Association approved the development of a committee composed of foreign medical graduates for the purpose of providing orientation and acculturation to America. The program is to include assistance in the English language for foreign medical graduates. The AMA committee met in March 1978.

Because of these activities in the American Medical Association and because of already available English and basic medical science courses, the Committee felt that it was unnecessary to duplicate these efforts and recommends that Resolution No. 50-78 be not adopted.

Mr. President, I move that Resolution No. 50-78 be **NOT** adopted.

The text of the resolution reads as follows:

WHEREAS, There is a growing number of unlicensed foreign medical graduates who are now U.S. citizens in the State of Ohio, and

WHEREAS, Inability to pass licensure examinations have forced them to accept paramedical positions such as surgical scrub technicians, detail men and even as morticians, and

WHEREAS, The State of Ohio stands to benefit from this additional manpower especially in the rural areas and inner cities if they were to qualify and continue to reside in this state, and

WHEREAS, There are certain provisions in P.L. 84-484 authorizing the Secretary of Health to fund such schools, THEREFORE, BE IT

RESOLVED, That the Ohio State Medical Association create an ad-hoc committee to conduct a statewide survey on the number of unlicensed non-U.S. graduates; and BE IT FURTHER

RESOLVED, That the OSMA cosponsor with a school preferably a medical school to conduct a comprehensive medical review in English and the basic sciences so that they may become better prepared to pass the licensure examination; and BE IT FURTHER

RESOLVED, That the OSMA encourage all medical societies to form a committee on Foreign Medical Graduates who

in turn shall forward their findings to the OSMA Ad Hoc Committee on FMGS. These societies can also assist in relocating foreign trained physicians needing services.

After some discussion, by official action, the House voted to refer Resolution 50-78 to the Council of the Ohio State Medical Association for study.

RESOLUTION NO. 57-78
Continuation of General Practice Residencies

Because the General Practice Residency Program has not been recognized by any other accreditation agencies for the past year and because the significance and goals of such a program might be misleading to the participant, the American Medical Association has removed this category from its future accreditation.

After deliberating, the Committee agrees with the position of the AMA and recommends that Resolution No. 57-78 be not adopted.

Mr. President, I move that Resolution No. 57-78 be **NOT** adopted.

By official action, the House voted to reject Resolution No. 57-78.

RESOLUTION NO. 58-78
Ohio Department of Public Welfare (Medicaid Division) Preadmission Review Forms

Mr. President, the Committee recognizes the need for a simplified nursing home preadmission review form and recommends the following Amended Resolution:

Amended Resolution No. 58-78

WHEREAS, The Ohio Department of Public Welfare is currently using a long and unwieldy preadmission review form to be completed and submitted by the physician before admission of his Welfare patients to nursing homes; and

WHEREAS, This may tend to delay hospital discharge and thereby contribute to an increase in cost of care; and

WHEREAS, It is reported that the Ohio Department of Public Welfare is currently developing a new, and possibly more complex, preadmission review form; THEREFORE, BE IT RESOLVED, That the President of OSMA refer this issue to the appropriate OSMA committee to assist the Ohio Department of Public Welfare in developing an acceptable and concise review form.

Mr. President, I move that Amended Resolution No. 58-78, be adopted.

By official action, the House voted to adopt Amended Resolution No. 58-78.

The report of Resolutions Committee No. 3, as a whole, as amended, was approved by the House.

INAUGURAL CEREMONY

Mrs. Wells was introduced and escorted to the podium by Dr. Richard E. Hartle. Dr. Bates then presented President's medallions to Dr. and Mrs. Wells and the certificate of honor to Dr. Wells.

Mrs. Gaughan, with their five daughters, was escorted to the podium by Dr. Robert J. White. After they were introduced to the House, Dr. Bates administered the presidential oath of office to Dr. Gaughan.

Dr. Wells thanked the staff for the execution of their assigned duties during the meeting and in the past year, and presented to the House for recognition Mrs. Gail Dodson and David Torrens, Director and Assistant Director of the Department of Continuing Medical Education, their staff, and Mrs. Carol Maddy, OSMA Coordinator of Records. Dr. Wells presented Dr. Gaughan the official gavel and the President's medallion. Dr. Gaughan presented to Dr. Wells the Past President's identification pin.

Dr. Gaughan gave a short address to the House.

At the close of the session, Dr. Gaughan recognized Dr. Harry K. Hines, Cincinnati. Dr. Hines thanked the House for his 16 years as a member of the AMA delegation.

There being no further business, the House of Delegates then adjourned *sine die*.

ATTEST: Hart F. Page, CAE
Executive Director



Singalongs, German Band, Cocktails and Keg Beer. All meats, desserts, and soups are made right here in Schmidt's immaculate kitchens. Ask to see. Buy Bratwurst and Bahama Mamas to take home. 4 blocks East of S. High St. on Kossuth, just a few blocks from your medical association headquarters.

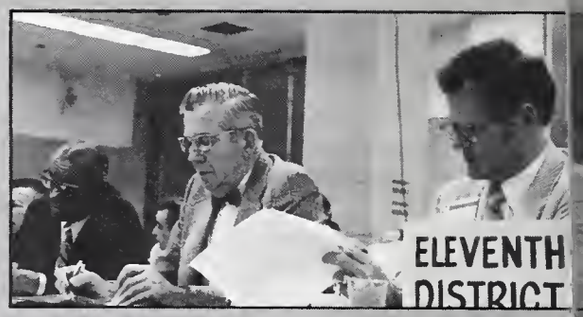
Fantastic new private party and meeting rooms serving German Buffet or any size sizzling Top Grade steak dinners. Reservations taken for parties 35 and up. Call 444-5050.

Liveliest Spot In German Village

Noon and Night











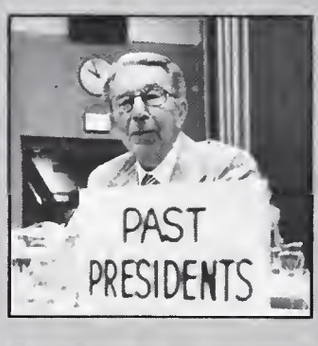




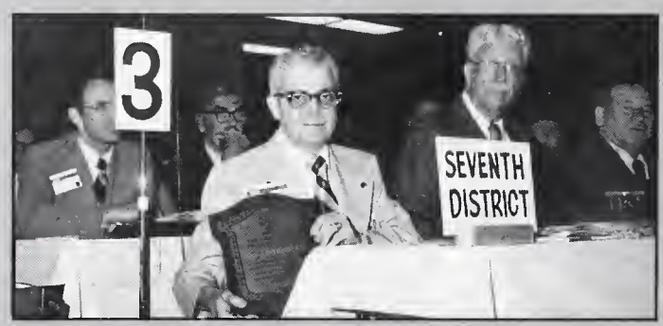




















Photographs by Linda A. Porterfield

(See page 455 for identification)

OSMA OFFICERS, COUNCILORS, AND AMA DELEGATES

Editor's Note: The following physicians are currently holding office.—L.A.P.

OFFICERS

John J. Gaughan, M.D., *President*
7911 Detroit Ave., Cleveland 44102

Thomas W. Morgan, M.D., *President-Elect*
Holzer Medical Center Clinic
P.O. Box 344, Gallipolis 45631

William M. Wells, M.D., *Past President*
241 Hudson Ave.
Newark 43055

Robert G. Thomas, M.D., *Secretary-Treasurer*
630 E. River St., Elyria 44035

COUNCILORS

Stewart B. Dunsker, M.D., *First District*
506 Oak Street, Cincinnati 45219

W. J. Lewis, M.D., *Second District*
2567 Far Hills Ave., Dayton 45419

Alford C. Diller, M.D., *Third District*
Med. Arts Bldg., 140 Fox Rd.
Van Wert 45891

C. Douglass Ford, M.D., *Fourth District*
2361 Bancroft St., Toledo 43607

Theodore J. Castele, M.D., *Fifth District*
18869 Canyon Road, Cleveland 44126

C. Edward Pichette, M.D., *Sixth District*
1019 Boardman-Canfield Rd.
Youngstown 44512

H. Judson Reamy, M.D., *Seventh District*
319 N. Tuscarawas Ave.
Box 219, Dover 44622

Richard E. Hartle, M.D., *Eighth District*
600 Pleasantville Rd., Lancaster 43130

A. Burton Payne, M.D., *Ninth District*
411 Center Street, Ironton 45638

J. Hutchison Williams, M.D., *Tenth District*
4355 Sharon Ave., Columbus 43214

S. Baird Pfahl, Jr., M.D., *Eleventh District*
521 W. Perkins Ave., Sandusky 44870

William Dorner, Jr., M.D., *Twelfth District*
750 W. Market St., Akron 44303

DELEGATES TO THE AMA

John E. Albers, M.D.
2350 Auburn Avenue, Cincinnati 45219

George N. Bates, M.D.
Med. Dir., Owens-Illinois, Inc.
P.O. Box 1035, Toledo 43601

Oscar W. Clarke, M.D.
Holzer Medical Center Clinic
Box 344, Gallipolis 45631

Jerry L. Hammon, M.D.
Veterans Administration, Brown Hospital
4100 W. Third Ave., Dayton 45428

W. J. Lewis, M.D.
2567 Far Hills Ave., Dayton 45419

H. William Porterfield, M.D.
1100 Morse Rd., Columbus 43229

P. John Robechek, M.D.
3461 Warrensville Center Rd., Cleveland 44122

Jack Schreiber, M.D.
Doctors Park, Canfield 44406

Robert N. Smith, M.D.
3424 Gallatin Rd., Toledo 43606

ALTERNATE DELEGATES TO THE AMA

Theodore J. Castele, M.D.
18869 Canyon Rd., Cleveland 44126

Stewart B. Dunsker, M.D.
506 Oak Street, Cincinnati 45219

C. Douglass Ford, M.D.
2361 W. Bancroft St., Toledo 43607

Thomas E. Fox, M.D.
309 Reading Road, Mason 45040

Richard L. Fulton, M.D.
2965 Pickwick Dr., Columbus 43221

John J. Gaughan, M.D.
7911 Detroit Ave., Cleveland 44102

Edward E. Grable, M.D.
2525 13th St., N.W., Canton 44708

B. Leslie Huffman, Jr., M.D.
5757 Monclova, Maumee 43577

Robert G. Thomas, M.D.
630 East River St., Elyria 44035

OSMA HEADQUARTERS EXECUTIVE STAFF

Executive Director
Hart F. Page

Department of Communications
Rebecca J. Doll, *Director*
Carol Mullinax, *Editorial Ass't.*

Department of Continuing Medical Education
Gail E. Dodson, *Director*
David C. Torrens, *Ass't. Director*

Department of Federal Legislation and Public Policy
Charles W. Edgar, *Director and Associate Executive Director*

Department of Field Service
Robert E. Holcomb, *Director*

Department of Government Relations
Herbert E. Gillen, *Director and Associate Executive Director*

Department of Health Education
Robert D. Clinger, *Director and Associate Executive Director*

Department of Membership and Finance
Katherine E. Wisse, *Comptroller and Associate Executive Director*

Department of Organization Services
Jerry J. Campbell, *Director and Associate Executive Director*

Department of State Legislation
D. Brent Mulgrew, Esq., *Director*
Richard A. Ayish, *Ass't. Director*

STAFF ASSOCIATES

Records Coordinator
Carol C. Maddy

Accounts Coordinator
Carolyn I. Gary

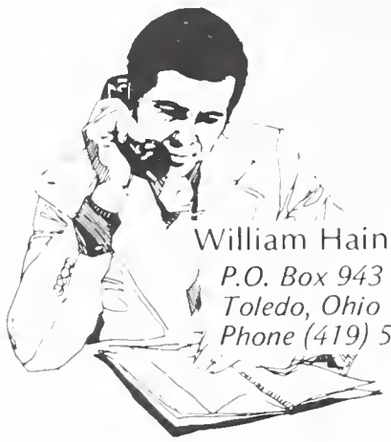
Organization Services Coordinator
Vickey L. McVay

THE OHIO STATE MEDICAL JOURNAL

Richard L. Meiling, M.D., *Consulting Medical Editor*

Linda A. Porterfield, *Executive Editor and Executive Business Manager*

Mary Lou Brady, *Editorial Ass't.*



William Hainen
P.O. Box 943
Toledo, Ohio 43656
Phone (419) 535-8041



Dan Negron
2400 Market Street
Youngstown, Ohio 44507
Phone (216) 783-9800

Your Blue Shield Expert



Frank Petsche
1351 Wm. Howard Taft Road
Cincinnati, Ohio 45206
Phone (513) 872-8381



Frank McEldowney
6740 North High Street
Worthington, Ohio 43085
Phone (614) 438-3686

THEY'RE HANDY PEOPLE TO HAVE AROUND

When you have a question, problem or concern about Blue Shield, we have the people who can help—your Ohio Medical Indemnity professional relations experts. Located right in your area, it's their job to short-cut...both physically and administratively...the distance between your office and our main office.

They're the people to call to get answers and action and save yourself time and trouble. They're nearby when you need help...and they'll go out of their way to see you get it.

If by some chance you haven't gotten acquainted with your Blue Shield professional relations experts, give them a call today. You'll find they're handy people to have around.

Blue Shield

Ohio Medical Indemnity, Inc.

We create impressions...

First impressions for physicians' waiting rooms. As in the contemporary style shown here, we will design a waiting room that reflects your concern for quality, serenity and most importantly, your patients' total comfort. We will blend style and function in every other room of your office as well. Create an impression . . . call us. We're Medical Interiors, a division of the Wendt-Bristol Company.



AMERICAN SURGICAL TRADE ASSOCIATION A.S.T.A.

medical interiors
a division of THE WENDT-BRISTOL CO.
1107 dublin road p.o. box 144
columbus, ohio 43216

☐ please send a brochure explaining your design concepts.
☐ I'm interested in learning more about MEDICAL INTERIORS.

the wendt-bristol company

NAME

ADDRESS

CITY STATE ZIP

OSMJ—7/78

Ohio State Medical Association Proceedings of the Council

The Council of the Ohio State Medical Association met May 7, 1978, at Stouffers' Dayton Plaza, Dayton, Ohio.

Those present were: Doctors William M. Wells, Newark; John J. Gaughan, Cleveland; George N. Bates, Toledo; Robert G. Thomas, Elyria; Stewart B. Dunsker, Cincinnati; W. J. Lewis, Dayton; Alford C. Diller, Van Wert; C. Douglass Ford, Toledo; C. Edward Pichette, Youngstown; Robert E. Rinderknecht, Dover; Richard E. Hartle, Lancaster; Thomas W. Morgan, Gallipolis; J. Hutchison Williams, Columbus; S. Baird Pfahl, Jr., Sandusky; and William Dorner, Jr., Akron. Also present were: Messrs. Pohlman, Page, Gillen, Campbell, Clinger, Mulgrew, and Ayish.

In accordance with Chapter 5, Section 4, of the Bylaws, the following candidates for the Council were reported to the Executive Director:

District 1:	Dr. Stewart B. Dunsker
District 3:	Dr. Alford C. Diller
District 5:	Dr. Theodore J. Castele
District 7:	Dr. H. Judson Reamy
District 9:	Dr. A. Burton Payne
District 11:	Dr. S. Baird Pfahl, Jr.

The Council voted to support Dr. John Beljan, Dayton, for election to the AMA Council on Scientific Affairs.

A standing ovation by the Council honored Dr. Wells for his leadership during 1977-1978.

The Council thanked Dr. Bates, Dr. Rinderknecht, and Dr. Morgan for their long and meritorious service on the Council.

ATTEST: Hart F. Page, CAE
Executive Director

TREAT THE SYMPTOMS IN THE GERIATRIC PATIENT

APATHY • IRRITABILITY
FORGETFULNESS • CONFUSION



Cerebro-Nicin® CAPSULES

A GENTLE CEREBRAL STIMULANT & VASODILATOR FOR GERIATRIC PATIENTS

Each CEREBRO-NICIN capsule contains:
Pentylenetetrazole .....100 mg. • Nicotinic Acid .....100 mg.
Ascorbic Acid .....100 mg. • Thiamine HCl .....25 mg.
l-Glutamic Acid .....50 mg. • Niacinamide .....5 mg.
Riboflavin .....2 mg. • Pyridoxine HCl .....3 mg.
AVAILABLE: Bottles 100, 500, 1000
SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and abdominal cramps. The reaction is usually transient.
INDICATIONS: As a cerebral stimulant and vasodilator.
RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.
WARNING: Overdosage may cause muscle tremor and convulsions.
CONTRAINDICATIONS: Epilepsy or low convulsive threshold.
CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

Write for literature and samples . . .
BROWN THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057

The Council of the Ohio State Medical Association met May 11, 1978, at Stouffers' Dayton Plaza, Dayton, Ohio.

All members of the Council were present. Dr. Gaughan introduced Dr. H. Judson Reamy, new Councilor from the Seventh District, and Dr. A. Burton Payne, newly elected Councilor from the Ninth District.

Dr. Gaughan submitted his appointments to eight Ad Hoc Council Operational Committees. They were **approved** by official action of the Council.

Appointments to 31 standing and special committees were then submitted by Dr. Gaughan and were **approved** by official action.

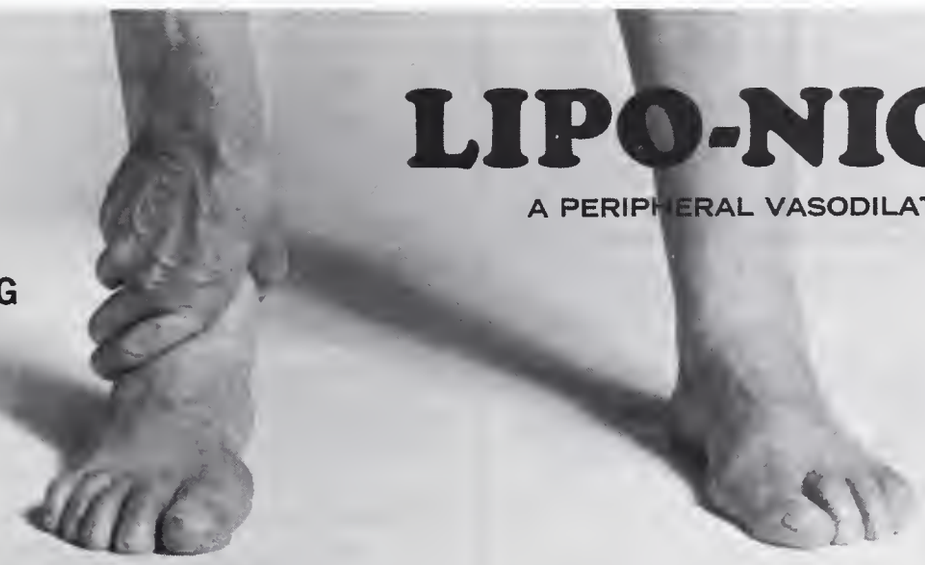
Mr. Ayish presented a protocol for participation in a "prisons and jails" pilot project financed by the American Medical Association. Participation of the OSMA was **approved** by the Council.

A matter in Highland County was discussed. It was the consensus that the Chief of the Medical Staff, the Chairman of the Board of Trustees, and the President of the Medical Society should be consulted.

With regard to a request from the Ohio Neurosurgical Section for assistance in the review of a neurosurgeon, the Council voted that through its president, the county medical society be invited to participate in the review; that the president be consulted and informed; and further that the Neurosurgical Section of OSMA be responsible for the review process.

ATTEST: Hart F. Page, CAE
Executive Director

COLD FEET
LEG CRAMPS
TINNITUS
DISCOMFORT ON STANDING



LIPO-NICIN
A PERIPHERAL VASODILATOR

IMMEDIATE or GRADUAL
nicotinic acid therapy

IMMEDIATE RELEASE

LIPO-NICIN/100 mg.
Each blue tablet contains:
Nicotinic Acid .....100 mg.
Niecinamide ..... 75 mg.
Ascorbic Acid .....150 mg.
Thiemine HCL (B-1) .. 25 mg.
Riboflevin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6).. 10 mg.
DOSE: 1 to 5 teblets daily.
AVAILABLE: Bottles of 100, 500, 1000.

LIPO-NICIN/250 mg.
Each yellow tablet contains:
Nicotinic Acid .....250 mg.
Niecinamide ..... 75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .. 25 mg.
Riboflavin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6).. 10 mg.
DOSE: 1 to 3 teblets daily.
AVAILABLE: Bottles of 100, 500, 1000.

GRADUAL RELEASE

LIPO-NICIN/300 mg.
Each time-release capsule contains:
Nicotinic Acid .....300 mg.
Ascorbic Acid .....150 mg.
Thlemine HCL (H-1) .. 25 mg.
Riboflevin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6).. 10 mg.
In a special base of prolonged therapeutic effect.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the llsted vitamins. The warm tingling flush which mey follow each dose of LIPO-NICIN 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient. Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbence may occur. Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

BROWN THE BROWN PHARMACEUTICAL CO., INC. 2500 West Sixth Street, Los Angeles, California 90057
Write for Literature and Samples
REFER TO PDR

This year . . . the chances of your being seriously disabled are far greater than death.

THIS CHART SHOWS JUST HOW MUCH GREATER.

CHANCES OF DISABILITY VS. DEATH	
If you are age:	A disability of 90 days or longer is this much more likely to occur than death this year
22	7½ TIMES GREATER
32	6½ TIMES GREATER
37	5½ TIMES GREATER
42	4 TIMES GREATER
47	3½ TIMES GREATER
52	2½ TIMES GREATER
62	2 TIMES GREATER

Source: The National Underwriter Company 420 E. 4th St. Cincinnati, Ohio 45202

When disability occurs, will your protection be adequate?

To be sure you have an income when you're disabled, enroll in . . .
THE DISABILITY INCOME PROTECTION PLAN which your Ohio State Medical Association co-sponsors with many local medical societies. You may apply for benefits up to $500 weekly.

CONTACT:

TURNER AND SHEPARD INC.

Columbus, Ohio 43215	17 South High Street	Phone (614) 228-6115
Akron, Ohio 44313	3090 West Market Street	Phone (216) 434-5000
Cincinnati, Ohio 45241	4015 Executive Park Drive	Phone (513) 563-4220
Cleveland, Ohio 44134	1440 Snow Road	Phone (216) 741-4466
Toledo, Ohio 43606	3450 West Central Avenue	Phone (419) 535-0616

The Ohio State Medical Association Obituaries

ROBERT BAIM, M.D., Sun City, Arizona; Wayne State University School of Medicine, Detroit, Michigan, 1936; age 72; died April 26; member OSMA and AMA.

ALBERT BERNDT, M.D., Portsmouth; University of Pennsylvania School of Medicine, Philadelphia, 1933; age 69; died April 18; member OSMA and AMA.

THOMAS G. BYRNE, M.D., Cincinnati; University of Cincinnati College of Medicine, 1953; age 53; died March 25; member OSMA.

VERA R. DRIMER, M.D., Cincinnati; Institutul de Medicina si Farmacie, Cluj, Romania, 1924; age 82; died May 4; member OSMA and AMA.

KATHRYN HOFFMAN, M.D., Milan; University of Michigan Medical School, Ann Arbor, 1936; age 67; died April 24; member OSMA and AMA.

JOSEPH KLEIN, M.D., Cleveland; Royal Academy of Budapest, Hungary, 1914; age 88; died April 19; member OSMA and AMA.

CHARLES N. LONG, M.D., Rockledge, Florida; Ohio State University College of Medicine, 1917; age 87; died April 17; member OSMA and AMA.

PERRY E. McCULLAGH, M.D., Cleveland; University Manitoba Faculty Medicine, St. Johns, Newfoundland, 1924; age 76; died April 11; member OSMA and AMA.

ROBERT P. MEADER, M.D., Canfield; University of Michigan Medical School, Ann Arbor, 1931; age 76; died April 13; member OSMA and AMA.

JOHN A. NORMAN, M.D., Akron; Northwestern University Medical School, Chicago, 1947; age 54; died April 17; member OSMA and AMA.

WILFORD NUSBAUM, M.D., Lancaster; Indiana University School of Medicine, Indianapolis, 1930; age 71; died May 13; member OSMA and AMA.

JOSEPH PRINCE, M.D., Kettering; Creighton Univeristy School of Medicine, Omaha, Nebraska, 1933; age 73; died May 18; member OSMA and AMA.

CARL R. REED, M.D., Lancaster; Ohio State University College of Medicine, 1945; age 58; died August 29, 1977; member OSMA and AMA.

WILLIAM SAWYER, M.D., Worthington; Ohio State University College of Medicine, 1956; age 49; died April 25; member OSMA and AMA.

LLOYD L. SPITLER, M.D., Captiva Island, Florida; Indiana University School of Medicine, Indianapolis, 1926; age 75; died April 1; member OSMA and AMA.

L. A. WILLOUGHBY, M.D., Toledo; Toledo Medical College, 1903; age 91; died April 11; member OSMA and AMA.

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

OHIO OFFICES:

CINCINNATI: Raam 700, 3333 Vine Street, (513) 751-0657, L. A. Flaherty

CLEVELAND: Suite 106, 23360 Chagrin Boulevard, Beachwoad 44122, (216) 464-9950
A. C. Spath, Jr., R. A. Zimmerman

COLUMBUS: 1989 West 5th Ave., (614) 486-3939, J. E. Hansel

TOLEDO: 1011 Sandusky St., Suite H, P.O. Box 331, Perrysburg 43551, (419) 874-8080, R. E. Stallter

we can provide some form of health insurance to . . .

99%

of OSMA members—regardless of health history

Comprehensive protection is available for you and your family with the OSMA sponsored Hospital Confinement Insurance Plan, comprehensive Major Medical Insurance and the Excess Major Medical Insurance Plan. Also available to Ohio physicians are Disability Income Coverage, Practice Overhead Expense Coverage, Life Insurance and Accidental Death, Dismemberment and Disability Insurance. Choose the plans that fill your insurance needs and send the coupon today for complete details. Or better yet for immediate information, call us collect!

Spencer W. Cunningham
DANIELS-HEAD & ASSOCIATES, INC.
Daniels-Head Building
Portsmouth, Ohio 45662
Telephone 614/354-4561

I have checked the plans in which I am most interested. Please send me complete details on how I can take advantage of this high value insurance protection at low group rates.

OSMA SPONSORED PLANS

☐ HOSPITAL CONFINEMENT INSURANCE PLAN
☐ COMPREHENSIVE MAJOR MEDICAL INSURANCE
☐ EXCESS MAJOR MEDICAL INSURANCE

ALSO AVAILABLE TO OHIO PHYSICIANS

☐ DISABILITY INCOME PROTECTION
☐ ACCIDENTAL DEATH, DISMEMBERMENT and DISABILITY INSURANCE
☐ PRACTICE OVERHEAD EXPENSE PROTECTION
☐ LIFE INSURANCE

Name_____

Address_____

City_____

State_____ Zip_____

A Difference in Theophylline Therapy

micro-pulverized

BRONKODYL® Capsules

brand of theophylline, USP anhydrous



- **Blood levels as fast as an elixir**
- **With minimal gastric irritation***

*Please see complete prescribing information, a summary of which follows.

DESCRIPTION:
Each green and white hard gelatin capsule contains theophylline USP anhydrous, 200 mg., in a micro-pulverized form. Each brown and white hard gelatin capsule contains 100 mg. The elixir contains 80 mg. theophylline per 15 ml. in a 20% alcohol elixir (approximately 20 calories, 0.9 gm carbohydrate per tablespoonful).

ACTION: Theophylline is a methylxanthine which relaxes the smooth musculature of the bronchioles through its inhibition of the conversion of cyclic adenosine monophosphate to adenosine monophosphate by phosphodiesterase. It also has diuretic, cardiotonic, and CNS stimulant effects.

INDICATIONS: Bronkodyl is indicated for symptomatic relaxation of bronchiolar spasm in the chronic obstructive bronchopulmonary diseases; e.g., bronchial asthma, chronic bronchitis and pulmonary emphysema.

CONTRAINDICATIONS: Bronkodyl is contraindicated in persons known to have had serious idiosyncratic responses to theophylline, its salts, or the other methylxanthines, theobromine, or caffeine and may be contraindicated in peptic ulcer.

WARNINGS: All methylxanthines should be used with caution in children and in others who are currently taking bronchodilator products, especially in rectal dosage form, which may contain theophylline or related drugs.

USAGE IN PREGNANCY: Although theophylline has been used for many years, with no evidence of adverse fetal effect or teratogenicity, its safety in pregnancy has not been established. Therefore use of Bronkodyl during lactation or in women of childbearing potential requires that possible benefits of the drug be weighed against possible hazards to fetus or child.

PRECAUTIONS: Bronkodyl should be used with caution in patients with cardiac or circulatory disease.

ADVERSE REACTIONS: Gastrointestinal: Epigastric distress, nausea, vomiting. Cardiovascular: palpitations. CNS: Insomnia, restlessness, irritability, convulsion.

DOSAGE AND ADMINISTRATION: Adults: Usual dosage of Bronkodyl is 200 mg. every 6 hours (four doses in each 24 hours). This dosage may be adjusted to reflect individual clinical response as an indication of slow or rapid metabolism of the drug. If adverse reactions are encountered, each dose may be reduced, or the interval between doses may be lengthened, or both. If clinical response is not satisfactory, indicating possible rapid inactivation of the drug, dosage may be gradually increased to achieve the desired response. In some instances of either too slow or too rapid metabolism, plasma levels of theophylline should be determined and dosage adjusted accordingly to achieve levels above 10 mcg/ml, but not to exceed 20 mcg/ml.

Dosage in Children: Usual dosage should be based on administration of 10 mg per kg per 24 hours, divided in 4 doses per day, given every 6 hours. As this may not be possible with use of the capsules, Bronkodyl elixir may be used. Theophylline saliva levels (approximately 60% of simultaneous blood levels), may facilitate dosage adjustments, especially in children, to obtain appropriate response.

HOW SUPPLIED:
Bronkodyl 100 mg., brown and white capsules in 100's, Code #1831.
Bronkodyl 200 mg., green and white capsules in 100's, Code #1833.
Bronkodyl Elixir, 80 mg. per 15 ml, in pints, Code #1835.

BREON LABORATORIES INC.
90 Park Avenue, New York, N.Y. 10016

Classified Ads

Rates: $3 per line. Display classified: $5 per line. Minimum 3 lines per insertion. Ads measure 8 lines to the inch. Box number reply: Flat $5 charge in addition to line cost for up to and including three insertions. (Covers cost of mailing replies which are kept confidential.) Forms close the 10th day of the month preceding month of publication. Address all ads Attention: Classified Ad Department, ***The Journal.***

To assure prompt delivery, when replying to an advertisement over a ***Journal*** box number, address letters as follows: Box (insert number), c/o ***The Ohio State Medical Journal***, 600 South High Street, Columbus, Ohio 43215.

MEDICAL DIRECTOR— OCCUPATIONAL HEALTH/PREVENTIVE MEDICINE: Ohio Bell Telephone Company has embarked on an expanded occupational health program and is seeking someone who is interested in participating in the organization's development and growth. This position is located at the company's headquarters in Cleveland. Internal medicine and/or occupational health background is helpful but not necessary; interest and desire is most important. Excellent fringe benefit package includes life, health, dental, and professional liability insurance; pension; savings plan; paid vacations, etc. Salary commensurate with other industries and in keeping with background training and experience. Send curriculum vitae to G. H. Franck, M.D., Corporate Medical Director, Ohio Bell Telephone Company, 100 Erieview Plaza, Room 910, Cleveland, Ohio 44114.

An Equal Opportunity Affirmative-Action Employer

OPHTHALMOLOGIST: Full-time position with multi-specialty group practice in southwestern Ohio very close to large metropolitan areas but with the advantages of family life in small city. First-year guarantee and excellent fringe benefit package with this incorporated professional group oriented to primary care. Conveniently accessible to continuing educational opportunities and university affiliation. Please reply to Box 829, c/o Ohio State Medical Journal.

AMBULATORY CARE CENTER — EMERGENCY DEPARTMENT STAFF PHYSICIAN, ATHENS, OHIO: 20,000 annual patient visits. Flexible scheduling, minimum guarantee/monthly bonus, excellent fringes. Contact Eric Jenison, M.D., O'Bleness Memorial Hospital, Athens, Ohio 45701, or call toll-free 800/325-3982 for details.

MEDICAL DIRECTOR & STAFF PHYSICIANS: County-owned-and-operated, long-term facility with skilled nursing, tuberculosis, pediatric, chronic illness, alcoholism detoxification and rehabilitation divisions. Full-time positions available immediately in 199-bed J.C.A.H. approved facility. Ohio State License required. Salary negotiable. For further information write to: Kathryn E. Shearer, Business Administrator, Molly Stark Hospital, Box 9122, Canton, Ohio 44711 or phone 216/875-5531.

SURGEON: Board-certified, wants to slow down. Seeking position with minimum 3-months, noncontinuous vacation annually. Reply to Box 832 c/o Ohio State Medical Journal.

MARION, OHIO: Excellent opportunities in Central Ohio. Existing and new, solo, partnerships, or association practices available and seeking physician support. Top compensation— reliable cross coverage. Exceptionally attractive, 250-bed, well-equipped regional medical center hospital within walking distance from offices. Industry and agriculture support city/45,000; county/65,000; and total trade area/250,000. Excellent schools and residential areas. Fifty-minute, easy drive to Columbus. Active need for—

FAMILY PRACTICE
INTERNAL MEDICINE
OTOLARYNGOLOGY
PEDIATRICS
ORTHOPEDIC SURGERY
EMERGENCY MEDICINE
GENERAL SURGERY

We are seeking either rural or city-oriented physicians. Send C.V. or contact— ROBERT FLINT, Marion General Hospital, MARION, OHIO 43302 — or call 614/382-8211 or 382-3442 any time.

CAPE COD: Falmouth, Massachusetts. Townhouse condominium. Private tennis, swimming. Near beaches, town. Almost new. Contact: Harold Bach, R.E., 617/540-0707.

FOR SALE: G.E. x-ray machine and equipment. Closing physician's office due to his death. Contact: B. Rambo, 367 S. Main St., Marion, Ohio 43302.

(Classified Ads continued on page 484)

PHYSICIAN: With empathy toward college-age population to practice general medicine in 38-bed accredited hospital with large outpatient clinic. Salary negotiable, excellent fringe benefits. Contact I. W. Combs, M.D., Director, Purdue University Student Hospital, West Lafayette, Indiana 47907, phone: 317/749-2441.

Equal Access/Equal Opportunity Employer

FAMILY PRACTICE — RURAL PRACTICE: Northwest/central rural/agrarian community of 1200/1500 needs family practice physician. Practice could expand to cover 3000/3500 population area. No physician now practicing. Community will support. Major regional hospital within driving distance. Contact ROBERT FLINT, MARION GENERAL HOSPITAL, MARION, OHIO 43302, phone 614/382-8211 or 382-3442.

MEDICAL DIRECTOR
Rehabilitation Hospital

Rehabilitation hospital with 515 beds seeks a Director qualified by clinical and administrative excellence.

The successful candidate will be preferably an internist or physiatrist; board certified; licensed to practice in Ohio; with at least 5 years of clinical practice beyond residency; plus leadership experience, such as an associate director or department head; and capable in promoting public relations.

Responsibility with commensurate authority includes direction of all medical programs, supervision of staff physicians and consultants, and all other facets related to medical directorship. Please send curriculum vitae in confidence to:

C. B. Mueller and R. L. Braddom, M.D.
The Daniel Drake Memorial Hospital
Galbraith Road at Vine Street
Cincinnati, Ohio 45216

An Equal Opportunity Employer M/F

SURGICAL HOUSE PHYSICIANS: Full training required. Excellent salary and fringe benefits, 48-hour week. Contact: J. Lopez, M.D., Director, Department of Surgery, St. Alexis Hospital, 5163 Broadway, Cleveland, Ohio 44127, phone 216/641-3300.

AVAILABLE: Long-established physician's office for rental or property purchase. Excellent practice opportunity for general practitioner. Reply to: 329 Vassar Avenue, Elyria, Ohio 44035.

POSITION AVAILABLE

I have available a position in my office for a qualified young physician interested in entering the private practice of Internal Medicine. My office is located in an eastern Cleveland suburb. The applicant must be either board certified or eligible in Internal Medicine or in one of the medical subspecialties.

I have a well-established practice in Internal Medicine, and entering practice with me would lead to an eventual full partnership.

I have an appointment at Case Western Reserve School of Medicine as Assistant Clinical Professor of Medicine. My clinical work is done at Mt. Sinai Hospital and Suburban Hospital.

Please send Curriculum Vitae to:

Allen J. Reisenfeld, M.D.
14100 Cedar Road — Suit 350
May Medical Building
University Hts., Ohio 44121

GYNECOLOGIST: To supplement present staff. Part-time or full-time, hrs. flexible. Highest compensation in area. May combine with private practice, teaching, or hospital practice. Reply to: Joseph M. Blaine, Women's Center, 173 E. McMillan, Cincinnati, Ohio 45219 or call 513/621-1515.

FOR SALE: Highest quality stainless steel surgical instruments for general, gynecologic, orthopedic, and G-U surgery. Very reasonable as I am retiring from active practice. Contact: Robert G. Smith, M.D., 214 E. Franklin St., Circleville, Ohio 43113. Phone: 614/474-2124 or 614/474-5680 (residence).

BLUE CHIP CORPORATIONS: Seek physicians. All fees paid. Openings for staff physicians, epidemiologists, clinical pathologists, clinical research, anti-inflammatory disease experience. Three positions in the Midwest. Salaries: $40,000 to $60,000. Send C.V. to: Gary Bell Associates, 393 Crescent Avenue, Wykoff, New Jersey 07481, Attn. Allen Cayne, or call 201/891-5900.

GENERAL MEDICAL OFFICES AVAILABLE FOR RENT: In Hartville, reportedly the fastest growing township in Ohio. New construction permitting individual furnishing. Physically attached to Cancer Center with diagnostic x-ray, laboratory, and pharmacy facilities. Contact George N. Swallon Agency, Canton, Ohio, 216/456-3495, or inquire of R. K. Loeffler, M.D., 650 South Prospect, Hartville, Ohio 44632.

FOR LEASE: 2,000 sq. ft. medical office suite in Columbus, Ohio (northwest area), many "built-ins," off-street parking, full services, immediate occupancy. Phone for floor plan drawing 614/263-5469.

GENERAL PRACTICE PHYSICIAN WANTED: Office space available. North-central Ohio, population area 25,000. Ideal environment, excellent sports, recreational facilities, boating nearby. Near Lake Erie islands recreation area. Midway Cleveland-Toledo, 100 miles north Columbus. Modern 68-bed hospital. Good schools. Brochure on request. Write Box 831, c/o Ohio State Medical Journal.

EMERGENCY PHYSICIANS: Full-time, career-oriented, northeast Ohio. Compensation commensurate with experience and training. Liberal fringe benefits, including professional liability insurance. Write: J. J. Cahill, M.D., 36001 Euclid Ave., Willoughby, Ohio 44094. Phone: 216/946-4546.

FAMILY PRACTICE PHYSICIANS: One or two. Excellent opportunity for private practice. Medical arts building available for lease or sale. Well-equipped, modern, three examination rooms. Parking space. Ten minutes to hospitals. Population of community including rural radius 4,000 to 5,000 persons. Low malpractice rates. Easily accessible to three major cities. Contact Mr. or Mrs. S. Roger Blackburn, Pharmacists, New Vienna Pharmacy, P.O. Box 194, New Vienna, Ohio 45159, phone: 513/987-2212.

MEDICAL DIRECTOR: Seeking board-certified/eligible physician with demonstrated clinical and administrative abilities. Rural 700-bed residential MR/DD habilitation center. Function as Assistant Superintendent in progressive, interdisciplinary setting. Supervise physician staff and paramedical services. Some direct service delivery. Knowledge of JCAH and ICF/MR desirable. Salary range up to $55,000 commensurate with qualifications, plus fringes. Ohio license eligibility required. Submit vita to Ms. M. Musser, Apple Creek State Institute, Box 148, Apple Creek, Ohio 44606. 216/698-2411 ext. 363.

An Affirmative Action
Equal Opportunity Employer



WINDSOR HOSPITAL

A NONPROFIT CORPORATION

— ESTABLISHED 1898 —

Chagrin Falls, Ohio

247 - 5300

A hospital for the treatment of Psychiatric Disorders

High on a Hill-Top, Overlooking Beautiful Chagrin River Valley.

Accredited by Joint Commission on Accreditation of Hospitals.

Booklet available on request.

FRIEDRICH A. LINGL, M.D., Medical Director
GUY H. WILLIAMS, JR., M.D., Medical Director Emeritus
HERBERT A. SIHLER Jr., President

MEMBER: American Hospital Association—National Association of Private Psychiatric Hospitals

AUGUST 1978
Volume 74, Number 8

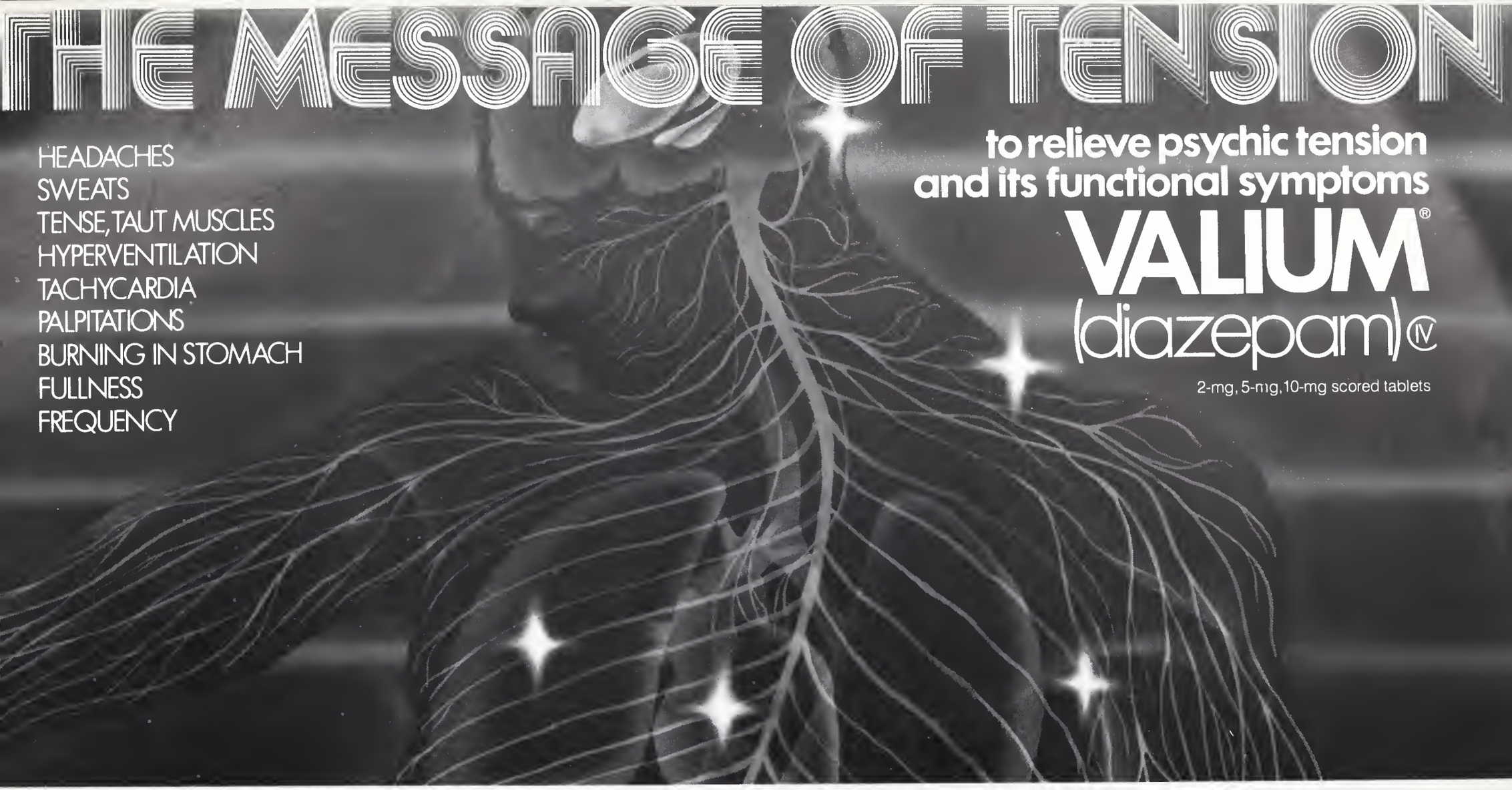
THE OHIO STATE Medical Journal



LIBRARY
U.C. SAN FRANCISCO
AUG 22 1978

PUBLISHED BY THE OHIO STATE

THE LIBRARY
ACQUISITIONS DIVISION
UNIVERSITY OF CALIFORNIA, SAN FRAN
SAN FRANCISCO, CALIFORNIA 94143



VALIUM®(diazepam)

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).
The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

OSMA OFFICERS
President
JOHN J. GAUGHAN, M.D.
7911 Detroit Avenue
Cleveland 44102
President-Elect
THOMAS W. MORGAN, M.D.
P.O. Box 344
Gallipolis 45631
Past President
WILLIAM M. WELLS, M.D.
241 Hudson Avenue
Newark 43055
Secretary-Treasurer
ROBERT G. THOMAS, M.D.
630 East River Street
Elyria 44035

EDITORIAL STAFF
Consulting Medical Editor
RICHARD L. MEILING, M.D.
Managing Editor and Business Mgr.
HART F. PAGE
Executive Editor and Executive Business Manager
LINDA A. PORTERFIELD
Editorial Assistant
MARY LOU BRADY
Communications Editor
REBECCA J. DOLL
Continuing Medical Education Editor
GAIL E. DODSON
Ass't. Continuing Medical Education Editor
DAVID C. TORRENS
Federal Legislation Editor
CHARLES W. EDGAR
Field Service Editor
ROBERT E. HOLCOMB
Government Relations Editor
HERBERT E. GILLEN
Health Education Editor
ROBERT D. CLINGER
Membership Editor
KATHERINE E. WISSE
Organization Services Editor
JERRY J. CAMPBELL
State Legislation Editor
D. BRENT MULGREW, ESQ.
Ass't. State Legislation Editor
RICHARD A. AYISH

Address All Correspondence, Address Change, & Reprint Request (unless otherwise noted):
Executive Editor
The Ohio State Medical Journal
600 South High Street
Columbus, Ohio 43215
Phone: 614/228-6971

Published monthly under the direction of The Council for and by members of The Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215, a scientific society, nonprofit organization, with a definite membership for scientific and educational purposes.

1979 Subscription: $15 per year, single copy $2 (outside U.S. $20 and $3).

Entered as second class matter July 5, 1905, at the Post Office at Athens, Ohio, under the Act of Congress of March 3, 1879. Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918. Second-Class Postage Paid at Athens, Ohio.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertisers must conform to policies and regulations established by The Council of the Ohio State Medical Association.

Publication office: 900 East State Street, Athens, Ohio 45701.

Printed by
The Lawhead Press, Inc., Athens, Ohio

VOL. 74 AUGUST 1978 NO. 8

THE OHIO STATE Medical Journal

Clinical and Scientific Articles

ST. LOUIS ENCEPHALITIS EPIDEMIC IN OHIO IN 1975 491
George W. Paulson, M.D., Columbus, and
Karl R. Brinker, M.D., Dallas, Texas

PREHOSPITAL EMERGENCY MEDICAL CARE IN OHIO 495
William H. Gates, Cincinnati

CANCER EDUCATION SERIES: HOW MUCH SURGERY FOR CANCER OF THE BREAST? 498
Arthur G. James, M.D., Columbus

Special Articles

WORKERS' COMPENSATION BUREAU CLARIFIES CONSULTANTS' SERVICES 504
Neil E. Webner, Columbus

REPORT ON THE 1978 ANNUAL MEETING OF THE AMERICAN MEDICAL ASSOCIATION 515
H. William Porterfield, M.D., Columbus, Delegate
Linda A. Porterfield, Columbus

ADDRESS OF THE PRESIDENT, AMERICAN MEDICAL ASSOCIATION 531
John H. Budd, M.D., Cleveland,
President, American Medical Association

Features

Letters to the Editor.....501
New Members.....502
Colleagues in the News.....507
Legislative Update — Federal...509
Continuing Education Programs..511
Obituaries.....513
News.....534
Journal Advertisers.....536
Classified Ads.....539
Placement Service Ads.....540

COVER: George W. Waylonis, M.D., Columbus, won an Outstanding Entry Award in the 1978 ***Ohio State Medical Journal*** Photographic Exhibit with this scene. Entitled "Beached for the Night," the photograph was taken one sunset evening in December 1976 with a Nikomat FTN and KBR-14 film. (Lens: 28 mm, aperture: 2:8, and speed: 1/30.)

Copyright 1978. The Ohio State Medical Association. All material subject to this copyright may be photocopied for the noncommercial purpose of scientific or educational advancement


"In a real dark night of the soul
it is always three o'clock in the morning."
—F. SCOTT FITZGERALD
THE CRACKUP, 1936

Insomnia
a shade of blue that often accompanies depression

And, in anxiety/depression, Adapin® (doxepin HCl) often helps restore disturbed sleep patterns, such as early morning awakening, with a single daily dose at bedtime.[1] Adapin quickly relieves the patient's anxiety, gradually brightens his mood and outlook, with optimal antidepressant response usually evident within two to three weeks.

1. Goldberg HL, Finnerty RJ, Cole JO: Doxepin: Is a single daily dose enough? *Am J Psychiatry* 131:1027-1029, 1974.

Brief Summary of Prescribing Information
ADAPIN® (doxepin HCl) Capsules

Indications—Relief of symptoms of anxiety and depression.

Contraindications—Glaucoma, tendency toward urinary retention, or hypersensitivity to doxepin.

Warnings—Adapin has not been evaluated for safety in pregnancy. No evidence of harm to the animal fetus has been shown in reproductive studies. There are no data concerning secretion in human milk, nor on effect in nursing infants.

Usage in children under 12 years of age is not recommended. MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with this drug, as serious side-effects and death have been reported with the concomitant use of certain drugs and MAO inhibitors.

In patients who may use alcohol excessively potentiation may increase the danger inherent in any suicide attempt or overdosage.

Precautions—Drowsiness may occur and patients should be cautioned against driving a motor vehicle or operating hazardous machinery. Since suicide is an inherent risk in depressed patients they should be closely supervised while receiving treatment. Although Adapin has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Adverse Reactions—Dry mouth, blurred vision and constipation have been reported. Drowsiness has also been observed.

Adverse effects occurring infrequently include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as sweating, tachycardia and hypotension. Weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash and pruritus may also occur.

Dosage and Administration—In mild to moderate anxiety and/or depression: 25 mg t.i.d. Increase or decrease the dosage according to individual response. Daily dosage, up to 150 mg may be taken at bedtime without loss of effectiveness. Usual optimum daily dosage is 75 mg to 150 mg per day not to exceed 300 mg per day.

Antianxiety effect usually precedes the antidepressant effect by two or three weeks.

How Supplied—Each capsule contains doxepin, as the hydrochloride: 10 mg, 25 mg, 50 mg and 100 mg capsules in bottles of 100 and 1000.

For complete prescribing information please see package insert or PDR.



When they see life in shades of blue... help them see life in all its colors.

Adapin®
(doxepin HCl)

single daily dose recommended h.s.



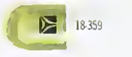
10 mg capsules



25 mg capsules



50 mg capsules



NEW 100 mg capsules

PENNWALT

Pennwalt Prescription Products
Pharmaceutical Division
Pennwalt Corporation
Rochester, New York 14603

ANCEF®

brand of sterile

CEFAZOLIN SODIUM

GETS TO THE SITE



OF SERIOUS RESPIRATORY INFECTIONS

'Ancef' Penetrates Pleural Fluid

"...levels of cefazolin in pleural fluid...generally exceeded the median MICs of all organisms commonly associated with respiratory tract infections, with the exception of a small number of isolates of Klebsiella and H. influenzae.

—Cole, D.R., et al.: Antimicrob. Ag. Chemother. 11(6):1033-1035 (June) 1977.

Tissue penetration is essential to therapeutic efficacy; however, specific tissue levels have not been directly correlated with specific therapeutic results.

Before prescribing, see complete prescribing information in SK&F literature or PDR. The following is a brief summary.

Indications: Ancef® (sterile cefazolin sodium, SK&F) is indicated in the treatment of the following serious infections due to susceptible organisms:

Respiratory tract infections due to Streptococcus pneumaniae (formerly D. pneumoniae), Klebsiella species, Hemophilus influenzae, Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), and group A beta-hemolytic streptocacci.

Injectable benzathine penicillin is considered to be the drug of choice in treatment and prevention of streptocaccal infections, including the prophylaxis of rheumatic fever. 'Ancef' is effective in the eradication of streptocacci from the nasopharynx; however, data establishing the efficacy of 'Ancef' in the subsequent prevention of rheumatic fever are not available at present.

Urinary tract infections due to Escherichia cali, Proteus mirabilis, Klebsiella species, and some strains of enterobacter and enterococci.

Skin structure infections due to Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), group A beta-hemolytic streptacacci and other strains of streptococci.

Biliary tract infections due to Escherichia coli, various strains of streptococci, Proteus mirabilis, Klebsiella species and Staphylococcus aureus.

Bone and joint infections due to Staphylocaccus aureus.

Genital infections (i.e., prostatitis, epididymitis) due to Escherichia coli, Proteus mirabilis, Klebsiella species, and some strains of enterococci.

Septicemia due to Streptococcus pneumoniae (formerly D. pneumoniae), Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), Proteus mirabilis, Escherichia coli, and Klebsiella species.

Endocarditis due to Staphylococcus aureus (penicillin-sensitive and penicillin-resistant) and graup A beta-hemolytic streptococci.

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to 'Ancef'.

Contraindications: ANCEF (STERILE CEFAZOLIN SODIUM, SK&F) IS CONTRAINDICATED IN PATIENTS WITH KNOWN ALLERGY TO THE CEPHALOSPORIN GROUP OF ANTIBIOTICS.

Warnings: BEFORE CEFAZOLIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY IN PENICILLIN-SENSITIVE PATIENTS.

SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence af partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Any patient who has demonstrated some form of allergy, particularly to drugs, should receive antibiotics cautiously. No exception should be made with regard to 'Ancef'.

Usage in Pregnancy: Safety of this praduct far use during pregnancy has not been established.

Usage in Infants: Safety for use in prematures and infants under 1 month of age has not been established.

Precautions: Prolonged use of 'Ancef' may result in the overgrowth of nansusceptible organisms. Careful clinical observation of the patient is essential.

When 'Ancef' is administered to patients with low urinary output because of impaired renal functian, lower daily dasage is required (see dosage instructions). A false positive reaction for glucose in the urine of patients on 'Ancef' has occurred with Clinitest® tablets salution.

Adverse Reactions: The following reactians have been reparted: **Hypersensitivity:** Drug fever, skin rash, vulvar pruritus, and eosinophilia have occurred. **Blaad:** Neutropenia, leukapenia, thrambacythemia and positive direct and indirect Coombs tests have accurred. **Hepatic and Renal:** Transient rise in SGOT, SGPT, BUN and alkaline phasphatase levels has been observed without clinical evidence of renal or hepatic impairment. **Gastraintestinal:** Nausea, anorexia, vomiting, diarrhea, aral candidiasis (oral thrush) have been reported. **Other:** Pain at site of injectian after intramuscular administration has occurred, some with induration. Phlebitis at site of injection has been noted. Other reactions have included genital and anal pruritus, genital moniliasis, and vaginitis.

How Supplied: Ancef® (sterile cefazolin sodium, SK&F)—supplied in vials equivalent to 250 mg., 500 mg., or 1 gram of cefazolin; in "Piggyback" Vials far intravenous admixture equivalent to 500 mg. or 1 gram of cefazolin; and in Pharmacy Bulk Vials equivalent to 5 grams or 10 grams of cefazolin.

ANCEF® IV IM

brand of sterile

CEFAZOLIN SODIUM

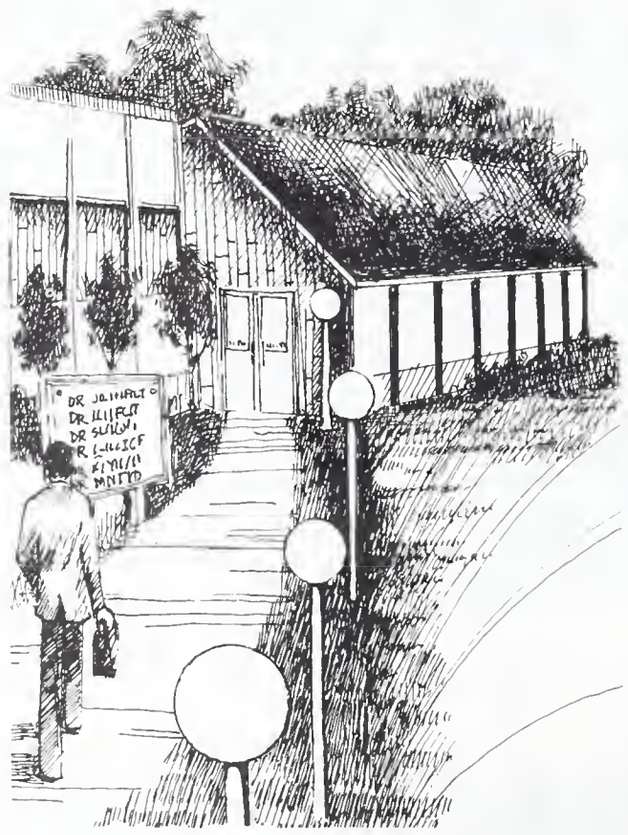
(LYOPHILIZED)

Injection: 250 mg., 500 mg. and 1 gram vials

Smith Kline &French Laboratories
Philadelphia, Pa.

SK&F
a SmithKline company

Physician's Office Protection Policy



The Physicians Insurance Company of Ohio is more than just professional liability protection. Much more.

PICO is also professional office protection.

PICO's Office Protection Policy for Physicians and Surgeons offers the kind of professional insurance coverage every physician needs. Policy features include coverage of the physician's buildings, insuring against all risks of physical loss. Coverage for equipment and property — including medical and surgical equipment and instruments, medical books, furniture and fixtures — insures against direct physical loss. The physician's premises are covered for claims arising from bodily injury and property damage.

PICO's Office Protection Policy for Physicians and Surgeons. For maximum professional protection. And considerable peace of mind.

Physicians Insurance Company of Ohio
6100 Channingway Boulevard
Columbus, Ohio 43227
(614) 864-3043

PICO

THE OHIO STATE Medical Association Clinical and Scientific

St. Louis Encephalitis Epidemic in Ohio in 1975

George W. Paulson, M.D.
Karl R. Brinker, M.D.

At least 388 cases of St. Louis encephalitis (SLE) occurred in Ohio in the summer of 1975. The major features of the disease were cephalgia and meningeal irritation, but some patients became comatose and a few deaths occurred. Prognosis for most patients was favorable. One of the common features of this disease is the development of the syndrome of inappropriate antidiuretic hormone (SIADH). This syndrome usually can be managed easily by fluid restriction. Electroencephalograms usually are abnormal during the acute phase of the illness; and they may be of some prognostic value if they return to normal quickly.

IN THE SUMMER OF 1975, Ohio experienced at least 388 cases of St. Louis encephalitis (SLE), and undoubtedly many times that number of patients had subclinical forms of the infection. All 388 cases of presumptive or confirmed encephalitis presented with neurologic symptomatology, most commonly cephalgia or meningeal irritation. This is a review of the major neurologic features observed from cases in Ohio, particularly in Franklin County. It includes a brief summary of some features of the epidemic as well as review of selected neurologic aspects of SLE.

Classification of Cases

All cases, classified as confirmed or presumptive infection with SLE, had a febrile illness and dysfunction of the central nervous system (CNS). Confirmed cases also manifested a fourfold rise in the titer of hemagglutination antibody (HAI-Ab), or compliment fixation antibodies (CCF-Ab), or a single HAI-Ab of 1/640 or above, or a single CF-Ab titer of 1/64 or greater.[1] Presumptive cases, as defined by the Ohio Department of Health, had a single HAI-Ab titer of at least 1/80, or a single CF-Ab titer of at least 1/32. Surveillance or ascertainment of cases depended on hospital reporting, and such reporting reflected the sophistication and interest of individual hospitals. Three counties with large hospitals had the greatest number of cases: Franklin (134 cases), Cuyahoga (84), and Montgomery (16). Overall attack rate in the state was 3.64 per 100,000 persons, but in Franklin County, it was 22.2 per 100,000 persons. Though records for all 388 patients were not available for detailed review, the average age was 46 years in the 150 patients for whom data were available at the Department of Health. Eighty-five percent were Caucasians, and there was an approximately equal sex distribution. The older patients seemed to be more ill than the younger ones. Results of brain scans were abnormal in 2.8%, and electroencephalograms (EEGs) were abnormal in 91% of the 85 patients known to be tested. Serum glutamic oxaloacetic transaminase (SGOT) was elevated in 10% and lactic dehydrogenase (LDH) in 15% of the 63 patients in whom these enzymes were checked. In the group of 150 patients, the serum sodium level was less than 130 in 25% of the patients. Six percent of the patients had a maculopapular rash as part of the illness. Antibiotics were given to 62% of the 150 cases for whom detailed data were available. Cases from one hospital, Riverside Methodist in Columbus, were studied during the last two weeks of the epidemic, using ten cases who manifested SLE. These patients, and those in the state that were reported to the Public Health Department, all had leukocytosis of the cerebrospinal fluid (CSF). In agreement with the literature, the total white blood cell (WBC) level in CSF was usually less than 300 cells, but it was over 600 in one case. The differential often included both polymorphonuclear cells and lymphocytes. The last ten patients seen at Riverside Methodist Hospital were

Dr. Paulson, Columbus, Neurologist, Riverside Methodist Hospital; and Clinical Professor of Neurology, The Ohio State University College of Medicine.
Dr. Brinker, Dallas, Texas, Fellow, Renal Service, University of Texas Southwestern Medical School at Dallas.
Submitted September 13, 1977.

evaluated by both a federal infectious disease specialist (Brinker) and a neurologist (Paulson). All patients had headaches, three had variable confusion, and one was in deep coma. Tremor was present at some phase of this illness in half of the patients; and one patient had severe opsoclonus and nystagmus. At least five of the patients manifested a low serum sodium level, and although not a proven test, the titers of ADH done at the acute phase of the illness were elevated in these patients. Similar results are available in other series in the literature.[2-5]

Epidemiology

It is known that SLE is transmitted by mosquitoes, and that the virus has an avian reservoir. Cases have been most numerous from boggy land or regions with sluggish streams, and as in the Texas report,[2,3] cases may be noted from the less affluent sections of town. Nevertheless, no area is likely to be spared in a major epidemic; such was the case in Ohio.

The infective agent is most commonly carried by urban birds such as sparrows, but SLE virus has been detected in numerous common birds, as was documented in Ohio in 1975. The year 1975 appeared to be a lush year for bird populations in Ohio, particularly for starlings; and infection in the avian population may have reduced the total population of birds since then. It is well known that bird populations can decline and that avian antibodies for the virus increase at times of epidemics.[5] Some investigators have suggested an increased incidence of infections in birds preceding human epidemics.[6]

In an epidemic summer, the disease appears in different portions of the nation at varied times; and in the past two decades, epidemics have appeared in Texas, Mississippi, Tennessee, and now from the Midwest. Most reports, with individual case exceptions, have suggested that SLE tends to be milder than many of the other arthropod-borne encephalitides. If recovery from SLE occurs, as can be anticipated in at least 90% of the reported cases, the patient rarely has a major deficit. In a few reports, mental change, tremor, seizures, or emotionality have been noted after the infection has subsided.

Neurologic Features

As can be ascertained from the cases, the most common neurologic feature was headache. It was of interest during the time of the epidemic, in midsummer of 1975, that numerous patients were seen who had *no* complaints when they were finally examined, but when the appointment had been made three or four weeks earlier, they had had intractable headaches, totally out of character in their medical history. The neurologic referral apparently came too late to detect the infection. It seems, and other data in the literature confirms this, that numerous subclinical cases of encephalitis occur during an overt epidemic. One article has suggested an attack rate of at least several dozen persons for each person clinically affected.[7] Headache was almost always the most common problem in alert patients with proven cases; confusion also was prominent in some patients. A stiff neck usually was present, but the neck rarely was as rigid as in patients with bacterial infections. The nuchal rigidity did not correlate with EEGs or other laboratory changes.

In several comatose patients, the serum sodium levels were below 125 mEq/liter. The Table documents the diuretic hormone levels in some of the patients, as reported from the Southwestern Laboratory in Dallas. It also cites representative serum osmolarity levels, done by freezing-point depression, for several patients admitted with SLE. As high as 50% of cases in some series of SLE manifest a low serum sodium level, and a syndrome of inappropriate secretion of antidiuretic hormone (SIADH) is often observed in this infection. Such SIADH usually is relatively mild, responds quickly to a reduction in fluid, and supplementary sodium is only needed rarely. There is no evidence of any other consistent metabolic disturbance in SLE, with the exception of occasional urinary tract infections and a mild elevation of liver enzymes in some patients. There is little evidence of clinical myositis or myocarditis. The occasional mild urinary or liver disturbances seen in some patients tends to confirm the generalized nature of the encephalitic process.

Individual patients may have opsoclonus, severe nystagmus and tremulousness, along with SLE. We have seen several patients who presented in an extremely atypical form, including one who had abdominal distress and a diagnosis of acute gallbladder disease until a lumbar puncture performed for nystagmus revealed aseptic meningitis. Another patient presented as having a possible neoplasm, and several were submitted to unnecessary angiography when encephalitis was overlooked or incorrectly diagnosed.

The diagnosis was both missed and overutilized. For example, patients with brain tumor or a vascular accident were initially considered to have SLE. One patient with a brain tumor became markedly worse after lumbar puncture. Hysteria was postulated in the first patient who was seen with a low serum sodium level. She was considered to be a compulsive water drinker because of insistence on drinking large amounts of water and a bizarre

Examples of Confirmed SIADH

Case	Serum Sodium mEq/Liter	Serum Urine Osmolality kg H_2O	ADH 2.5 + ng/l (normal)
1.	130	260/385	11.0
2.	119	253/624	11.3
3.	118	266/538	5.5
4.	121	272/646	9.0
5.	127	283/258	12.0
6.	120	242/332	13.5
7.	120	289/550	—

behavior. At least one patient had a subdural hematoma which was overlooked in the initial rush to diagnose SLE. Cases of aseptic meningitis are easily identified after an epidemic is recognized, but during an epidemic, the clinician cannot stop thinking of other treatable disorders, including bacterial meningitis.

There are no other major medical complications of SLE. A few review articles have suggested abnormalities in the electromyogram (EMG), but clinical myositis is not present, and the EMG was normal in six cases from Franklin County.

Use of the EEG

Six patients in the last phase of the epidemic were studied serially with EEGs, and several others had isolated tracings. The EEG from only one patient retained slight slowing; all other tracings returned to normal as the patients recovered. This encouraging electrical outcome occurred despite an age of above 60 years in at least five of the patients. In the series of 85 patients from around the state, 91% had an abnormal EEG. Thus, EEGs are confirmed as a useful diagnostic clue to the presence of encephalitis, and there are extensive reviews of encephalitis and EEG changes.[8] Observation of the EEG in encephalitis began early with studies of rubeola, in which as high as 50% of children with active measles had EEG abnormalities during the acute phase of the infection. Bilaterial, diffuse slowing is noted with many types of encephalitis, and is now considered nonspecific. Occasionally, periodic or repetitive discharges are noted in encephalitis, such as in herpes encephalitis.[9] Some of the more chronic or smoldering types of encephalitis, such as subacute sclerosing panencephalitis (SSPE), are manifested by quite striking EEG changes, again with periodic discharges.[10] Several of the patients with SLE did manifest bursts of high-voltage, slow activity at intervals of 10 to 20 seconds, but the predictable periodicity so characteristic of SSPE was not prominent in any of these. Patients with brain abscesses almost invariably demonstrate a marked slow-wave change in the EEG, and the abnormality often is very focal. Unless there is increased intracranial pressure, rhythmic frontal slowing, such as seen in SLE, is not noted in the average patient with a unilateral brain abscess. No cases with SLE had a predominantly unilateral disturbance in the EEG.

In SLE, the EEG is of particular value in indicating a diffuse, generalized, CNS disorder in a patient in whom such dysfunction has not been suspected. In addition, serial EEGs may give documentation as to prognosis since if improvement in the EEG occurs rapidly, the patient may be expected to have a favorable prognosis. Perhaps the most important use of the EEG is to rule out focal neurosurgical disorders, such as abscess, and to distinguish the more periodic chronic encephalitides, such as herpes and SSPE, from SLE. A normal EEG in an asymptomatic patient suggests that the diagnosis of SLE is unlikely. During the encephalitis season, chronic, unexplained headache is quite sufficient grounds for an EEG; many such patients may manifest a subclinical encephalitic process.

Treatment

Use of antibiotics in almost half of the 150 cases for which data are available does not prove need for such therapy. Early in an epidemic, an aseptic meningitis may be interpreted as incompletely treated bacterial meningitis, or as an abscess. Nevertheless, supportive care and caution in the management of SIADH usually is all that is indicated for SLE, once an epidemic is confirmed by techniques already available at the Ohio Department of Health.[11]

Summary

At least 388 cases of St. Louis encephalitis (SLE) occurred in Ohio in the summer of 1975. The major features of the disease were cephalgia and meningeal irritation, but some patients became comatose and a few deaths occurred. Prognosis was favorable for most patients. A common feature of this disease is the development of the syndrome of inappropriate antidiurectic hormone. This syndrome usually can be managed easily by fluid restriction. Electroencephalograms usually are abnormal during the acute phase of the illness; they may be of some prognostic value if they return to normal quickly.

Acknowledgement: Mr. Taylor R. Kramer, Ohio Department of Health, assisted with this report.

References

1. Jennings MR, Halpin TJ: St. *Louis Encephalitis-Ohio 1975, Interim Report,* March 15, 1976. Unpublished data supplied by Kramer TR, Ohio Department of Health, 1977.
2. Hopkins CC, Hollinger FB, Johnson RF, et al: Original contributions, the epidemiology of St. Louis encephalitis in Dallas, Texas, 1966. *Am J Epidemiol* **102**:1-14, 1975.
3. Epidemic St. Louis encephalitis in Houston, 1964. A conservative study. *JAMA* **193**:139-146, 1965.
4. Southern PM, Smith JW, Luby JP, et al: Clinical and laboratory features of epidemic St. Louis encephalitis. *Ann Intern Med* **71**:681-689,1969.
5. Lord RD, Calisher CH, Chappel WA, et al: Urban St. Louis encephalitis surveillance through wild birds. *Am J Epidemiol* **99**:360-363, 1974.
6. Lord RD, Calisher CH, Doughty WP: Assessment of bird involvement in three urban St. Louis encephalitis epidemics. *Am J Epidemiol* **99**:364-367, 1974.
7. Brody JA, Burns KF, Browning G, et al: Apparent and inapparent attack rates for St. Louis encephalitis in a selected population. *N Engl J Med* **261**:644-646, 1959.
8. Cobb WA: Electroencephalographic changes in viral encephalitis, in *Viral Diseases of the Central Nervous System* (ed 1), London, Cassel & Collier Macmillan, 1975, pp 76-89.
9. Smith JB, Westmoreland BF, Reagan TJ, et al: A Distinctive EEG Profile in Herpes Simplex Encephalitis. Presented in part at the meeting of the American Academy of Neurology, Boston, April 26-28, 1973.
10. Paulson GW: Subacute sclerosing panencephalitis. *Ohio State Med J* **71**:695-697, 1975.
11. White MG, et al: Pathophysiology of epidemic St. Louis encephalitis. *Ann Intern Med* **71**:691-702, 1969.

THREE-IN-ONE THERAPY AGAINST TOPICAL INFECTION



Neosporin® Ointment

(Polymyxin B-Bacitracin-Neomycin)

This potent broad-spectrum antibacterial provides overlapping action to help combat infection caused by common susceptible pathogens (including staph and strep). The petrolatum base is gently occlusive, protective and enhances spreading.

Neomycin
Staphylococcus
Haemophilus
Klebsiella
Aerobacter
Escherichia
Proteus
Corynebacterium
Streptococcus
Pneumococcus

Bacitracin
Staphylococcus
Corynebacterium
Streptococcus
Pneumococcus

Polymyxin B
Pseudomonas
Haemophilus
Klebsiella
Aerobacter
Escherichia

In vitro overlapping antibacterial action of Neosporin® Ointment (polymyxin B-bacitracin-neomycin).

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Neosporin® Ointment

(Polymyxin B-Bacitracin-Neomycin)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

Prehospital Emergency Medical Care in Ohio

William H. Gates, M.D.

Recent changes in federal and state law, organization of emergency medical systems, and provision of life-soving emergency medical procedures by nonphysician personnel prior to hospitol treatment have combined to significontly alter prehospital emergency medical core. Recent chonges in the low in Ohio for emergency medicol systems are described, including immunity from liobility for physicions. New concepts in providing emergency prehospital core hove increased the importance of emergency medicol systems. Foctors requiring direct physicion involvement are discussed. The quality control of improvement in emergency medicol services depends upon the individual physicion's leadership and porticipation.

PREHOSPITAL EMERGENCY medical care in the United States has undergone a profound change during the last five years. The numerous groups involved in this type of care were reorganized as "providers of emergency prehospital care" by the Health, Education and Welfare Act of 1973-1974. Amended in 1976, this Act also established grants available to those who reassessed their current methods for delivery of prehospital emergency health care, thus encouraging groups of providers to organize "systems" covering regional geographic areas.

Throughout the development of these systems, several common themes became visible.

1. Physician involvement was mandatory in all aspects of the system, including organization, planning, delivery, and supervision of prehospital emergency health care.

2. The natural "patient watershed" for the geographic area involved in the emergency medical system should be maintained.

3. The system required involvement of local government officials, community leaders, consumers, major businesses, and industry as well as the providers of emergency care (ie, hospitals, medical societies, fire and police departments, rescue services, and other official emergency response forces).

The Emergency Medical Systems (EMS), organized under the HEW Act of 1973, must demonstrate clearly their objectives, goals, and operating procedures. Specifically, they are required to address each of 15 components: manpower, training, communications, transportation, facilities, critical care units, consumer participation, public-service-agency resource coordination, mutual aid agreements, accessibility to care, transfer of patients, standard patient medical record keeping, public information, evaluation, and disaster linkages. It is important to note that the funds provided by the HEW Act were so-called "start-up funds," to be used as matching grants for local funds. These funds would be provided by the various entities organizing themselves into an EMS in order to show their direct financial support. This requirement was intended to demonstrate that local elected officials and the population which the EMS served would continue to support the EMS after the federal grants expired.

Emergency Medical Systems in Ohio

Needless to say, the current state of EMS in this country is one of dynamism. In some areas, EMS services are flourishing by using the HEW concept; whereas, the HEW concept does not appear to be adaptable in other areas. Where reasonably sophisticated emergency prehospital services already exist, the HEW concept is deemed unnecessary and, indeed, objectionable. In some suburban and rural areas, local provincial autonomy is threatened by altering the present means by which emergency medical prehospital care is delivered.

Currently, there are four major Emergency Medical Service Systems in operation in the State of Ohio. These have acquired direct official support from the citizens.* There are four others in various stages of planning. In those areas of the state where an EMS has not been formed, prehospital care is provided in many forms. After August 31, 1979, prehospital emergency care in Ohio will be supplied by certified emergency medical technicians and/or paramedics. These personnel can be volunteer, part-time, full-time paid, or privately hired. They may come from police departments, funeral homes and private ambulance companies, or independent rescue squads; but the majority are supplied by fire departments.

Immunity From Liability

In August 1976, House Bill 832 became law (Ohio Revised Code 4731.82). For the first time in Ohio, specific immunity from liability was given to squadmen

Dr. Gates, Cincinnati, is a member of the Attending Staffs, Good Samaritan and Providence Hospitals, and Courtesy Staffs, St. George and St. Francis Hospitals; and Chairman, State of Ohio Emergency Medical Services Advisory Council and OSMA Committee on Emergency and Disaster Medical Care.

Submitted April 18, 1978.

*The EMS systems are Regional Emergency Medical System Northwest Ohio (REMSNO), Western Ohio EMS, Cleveland EMS, and Southeast Ohio EMS (SOEMS).

(EMT-A or EMT-paramedic) while providing prehospital emergency care and to those physicians, nurses, and other hospital personnel specifically involved in the support of these prehospital-emergency-care personnel. To obtain immunity, the law required that each EMT-A and each EMT-P receive certification that he/she has completed a basic set of educational requirements. These standards were clearly spelled out in HB 832. In addition, all institutions involved in training these personnel must be certified.

The new law established the Board of Regents of the State of Ohio as the body responsible for the training standards and certification of paramedics. The Board of Education, Trade and Industrial Division, Emergency Medical Services Office was given the responsibility for the training standards and certification of EMT-As. The law establishes penalties for any noncertified personnel who performs emergency medical care in the field as part of an official emergency medical service. The acts that constitute emergency medical services have been clearly defined in the law.

This law did not change the Good Samaritan Act. Basically, this act protects any person attempting to assist an injured or ill person, provided no fee is charged for that service and no willful or wanton misconduct can be proved in the actions of the assisting individual. Another important point is that HB 832 does not apply to physicians practicing in their offices or in the hospital, but it does provide immunity if they are giving support during direct involvement with rescue squads and paramedics in their care of injured or ill persons in the community. A subsequent law — Senate Bill 209 — Ohio Revised Code 2305.23 — has given immunity to any official primary emergency responder attempting to give initial emergency care (ie, policemen, or firefighters).

Importance of EMS

An Emergency Medical System requires reorganization of the method by which rescue squads and others provide prehospital emergency care. However, this reorganization brings much more sophisticated care to the patient in a much shorter time. In effect, it has removed the barriers around the hospital critical care areas such as the coronary care unit, intensive care unit, operating room, recovery room, and emergency department — and has placed the procedures previously performed by physicians and some nurses directly into the community. The trained EMT-paramedic who arrives at the scene now has the capability to provide these emergency life-saving techniques (ie, endotracheal intubation, drugs, and defibrillation) at the patient's home or on the street corner where the emergency medical problem has occurred. Thus, life support techniques and procedures are begun before the patient is transported to the hospital.

The organization of an Emergency Medical System requires certain changes.

Public Education and Information. — The average citizen must learn to perform cardio-pulmonary resuscitation; to recognize that a severe medical emergency is occurring in an individual; and must have a uniform, highly visible means of gaining immediate access to the emergency response system (ie, emergency number on every telephone).

Central Dispatching, wherever possible, for all emergency response rescue services so that instant dispatching of rescue personnel can occur.

Certification of Training to assure the quality of the rescue personnel.

Use of Properly Designed Vehicles with specific emergency supplies and equipment.

Transport of the Patient to a qualified medical facility rated by its medical community to be capable of caring for the patient's needs.

Uniform Guidelines for Hospital-to-Hospital Transfer of a patient requiring tertiary care (specific subspecialty care).

Physician Participation

At the present time in Ohio, the number of paramedics is rapidly increasing. Without the direct support and participation of physicians, no supervision of the emergency medical functons of the paramedics can occur. This supervision is accomplished through telemetry as well as through certification and recertification training modes. At the present time, the State Board of Education, Trade and Industrial Division has requested that physicians become instructors in the recertification process.

The average physician must assess his ability to perform the same functions that trained paramedics execute almost daily. These include endotracheal intubation, treatment with specific drugs for cardiac arrythmias, defibrillation, administration of intravenous fluids, and other emergency procedures. Self-assessment can be accomplished by yearly participation in the advanced cardiac-life-support courses now being offered through the American Medical Association, Ohio State Medical Association, American Heart Association, and other organizations. In addition, physicians should have some knowledge or experience in techniques mastered by all rescue services, including immobilization and transport techniques for critically injured patients and basic knowledge of types of general field operations.

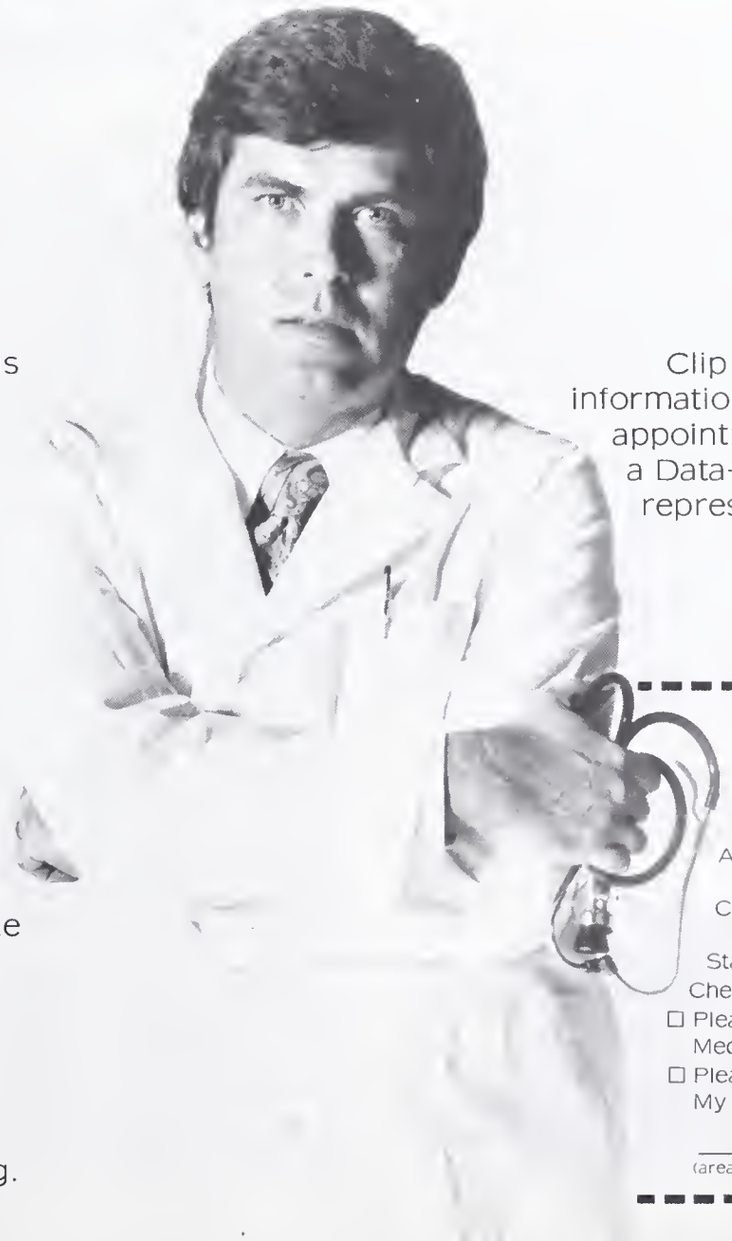
The physician also must become directly involved in evaluating and planning disaster linkages with emergency rescue forces for his community. This involves disaster planning with fire departments and hospitals in the physician's area of practice.

Summary

All physicians should realize that improvement in the quality of prehospital emergency care requires their active participation as patient advocates. It may not be necessary for every area of the state to be reorganized into the classic EMS in order to provide improvement in the baseline emergency medical services provided in the community. However, the need to provide the same basic standards of improved prehospital emergency medical care for every citizen, regardless of where he lives and/or works in Ohio, requires a concerted effort by all physicians to visibly support that goal.

Medical Data-Plan®

We're not offering you just a computerized billing system. We're offering you a way to plan the future of your practice.



Medical Data-Plan is a computerized system for getting bills out, processing insurance forms, speeding up cash flow and improving collections.

It also gives you the information you need to plan the future of your practice . . . 3 years, 5 years, 10 years from now.

Based on a steady flow of accurate, timely computer reports, your business manager can make sound recommendations on personnel, equipment, materials, facilities and more. Medical Data-Plan can show you what your practice has been doing—and what it should be doing.

Clip this coupon to receive information or to arrange an appointment with a Data-Plan representative.

Data-Plan

ON

Medical Data-Plan
Box 7947, Madison, Wisconsin 53707

Name _____

Address _____

City _____

State _____ Zip _____

Check one or both boxes below:

☐ Please mail me more information about Medical Data-Plan.

☐ Please have a representative contact me. My phone number is:

_____
(area code) (number)

Medical Data-Plan, Box 7947, Madison, Wisconsin 53707

THE OHIO STATE Medical Association Cancer Education Series*

How Much Surgery for Cancer of the Breast?

Arthur G. James, M.D.

SINCE MUCH EMPHASIS has been placed on the importance of the breast in the overall sexual attractiveness of women, it is easy to understand the anxiety a woman has when she discovers a lump in her breast, either accidentally or during her regular breast self-examination. Frightened at the possibility of having a breast cancer and losing her breast, she seeks medical advice. She has read in lay magazines that a simple mastectomy produces results as good as a radical mastectomy. She reads an article by Dr. George Crile, Jr. that a lumpectomy is all that is necessary for cure. She turns on her television to a talk show and hears a doctor state that breast cancer should be treated by radiation therapy, and that removal of the breast is not necessary.

It is easy to understand why women are confused today as to what to do about breast cancer. Depending on the patient's general level of stability, age, marital status, family history, and occupation, the reaction to finding a lump in her breast is one of varying degrees of apprehension, fear, and uncertainty. When asked what I do if a breast mass is malignant, this is my present attitude concerning the various surgical procedures for breast cancer.

Biopsy

Most often, the biopsy of breast tissue is done with the definite and specific understanding that if the result is positive, we will proceed with a definitive procedure. At times, a patient is not prepared for this psychologically. In such cases, we reach an agreement to perform a biopsy only and make a decision concerning definite surgery after the fixed tissue specimens are examined. It has been shown that a delay of up to three weeks between biopsy and definitive surgery does not alter the end results.

Lumpectomy

This procedure has no place in the curative surgical armamentarium of breast cancer. In 1971, Farrow, et al reviewed 77 cases treated by biopsy alone plus radiation therapy, or by local excision of the tumor (lumpectomy) plus radiation therapy.[1] Data for these cases were accumulated by the Memorial Cancer Center and New York Hospital in New York City and the M. D. Anderson Cancer Center in Houston. They represented patients who either refused further surgery or whose general medical condition was very poor. The records of many consecutive radical mastectomies with or without postoperative radiation therapy were reviewed to find an equal number with clinical findings similar to the biopsy-only and the lumpectomy groups. This study considered age, menstrual status, tumor size and location, and histologic diagnosis of the primary tumor, as well as the clinical interpretation of the ipsilateral lymph node status. At the end of ten years, 48% of the patients who underwent radical mastectomy were free of disease, whereas only 2.6% of those patients

Dr. James, Columbus, Professor of Surgery; Chief, Division of Surgical Oncology, The Ohio State University College of Medicine.
Submitted May 24, 1978.

The Journal is pleased to publish this series through the cooperation of the OSMA Committee on Cancer and the American Cancer Society, Ohio Division, Inc.

who had biopsy plus radiation and 5.8% who had simple excision (lumpectomy) plus radiation were living and free of disease.

Simple Mastectomy

This is not recommended as a curative procedure alone or when combined with radiation therapy. If the patient's medical condition is poor, I perform a simple mastectomy. I also advise this procedure for a carcinoma previously treated by radiation and/or chemotherapy when a residual mass persists in the breast. A simple mastectomy also can be done as a palliative procedure to remove an odoriferous or bleeding ulcerated breast.

Modified Radical Mastectomy

Many differing procedures are performed as modified radical mastectomies. They vary from a simple mastectomy plus the plucking of the lower axillary nodes only, to a careful dissection of the breast and a complete axillary dissection in continuity, sparing the pectoral muscles.

This procedure is advised (1) when the patient has minimal cancer — a primary lesion 1 cm or less in diameter with clinical negative nodes or in situ cancer; or (2) when the patient's general medical condition is not adequate for a radical procedure.

Modified radical mastectomy is becoming more and more popular with surgeons. If done properly, and this includes transecting the insertion of the pectoral minor muscle when necessary, it is possible to perform a good axillary dissection and to recover as large a number of lymph nodes as are recovered when muscles are removed.

It must be remembered, however, that the lymphatics from the breast traverse the pectoral muscles enroute to the axillary nodes and muscle recurrences have been found in these lymphatics. This is more often the case with lesions in the medial portion of the breast.

If a modified radical mastectomy is to be performed, I believe it should be done with the same principles in mind as in a radical mastectomy. The skin flaps should be developed just as thin and just as far as in the radical procedure. Dissection should be such that the procedure could be called *a radical mastectomy with preservation of the pectoral muscles.*

Radical Mastectomy

The standard Halsted radical mastectomy remains the procedure of choice for the patient in good general physical condition, and is the one that I perform over 90% of the time. This operation still offers about a 10% better chance of ten-year survival than any other surgical procedure. Leak, et al[2] compared the ten-year end results of a group of patients treated by radical mastectomy, one by modified radical, and one by simple mastectomy. The three groups were similar as far as tumor size and node involvement were concerned. They noted a ten-year-survival rate of 52% for radical mastectomy, 41% for the modified radical, and 31% for the simple mastectomy group.

The deformity the patient objects to is that produced by the loss of the breast. The deformity produced by a radical mastectomy is not much greater than that which results after a modified radical mastectomy. Arm function usually is just as good, and arm edema is not greater following the radical as compared with the modified radical mastectomy. It is true that breast reconstruction is easier if the muscles are left in place.

I believe the patient should be allowed a choice between the radical and the modified radical as long as she understands that the modified procedure reduces her chances for survival somewhat.

References

1. Farrow JH, Fracchia AA, Robbins GF, et al: Simple excision or biopsy plus radiation therapy as the primary treatment for potentially curable cancer of the breast. *Cancer* 28:1195-1201, 1971.
2. Leak GH, Berg J, Wesp EH, et al: Primary treatment of patients with resectable breast carcinoma. *Surg Gynecol Obstet* 129:935-959, 1969.

1978 ANNUAL CANCER SYMPOSIUM (Recent Advances in the Diagnosis and Treatment of Cancer): October 8, 8:30 AM - 4:30 PM; Fawcett Center for Tomorrow, Columbus; sponsor: American Cancer Society, Ohio Division, Inc.; cosponsors: Ohio State University Cancer Center and Northeast Ohio Cancer Center; application made for Category I credit; contact: American Cancer Society, Ohio Division, Inc., 1367 E. Sixth St., Cleveland 44114, phone: 216/771-6700.

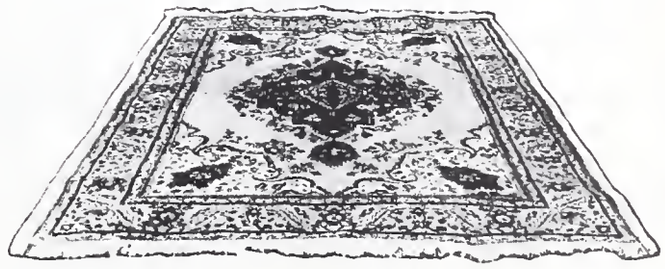
In Columbus
for over 65 years, since 1909,
K. A. Menendian
has been known for
the finest quality and best values in
ORIENTAL RUGS.

We carry a complete selection of rugs from mats to mansion sizes. Over 1500 rugs in stock from Iran, India, China, Pakistan, Turkey, etc.

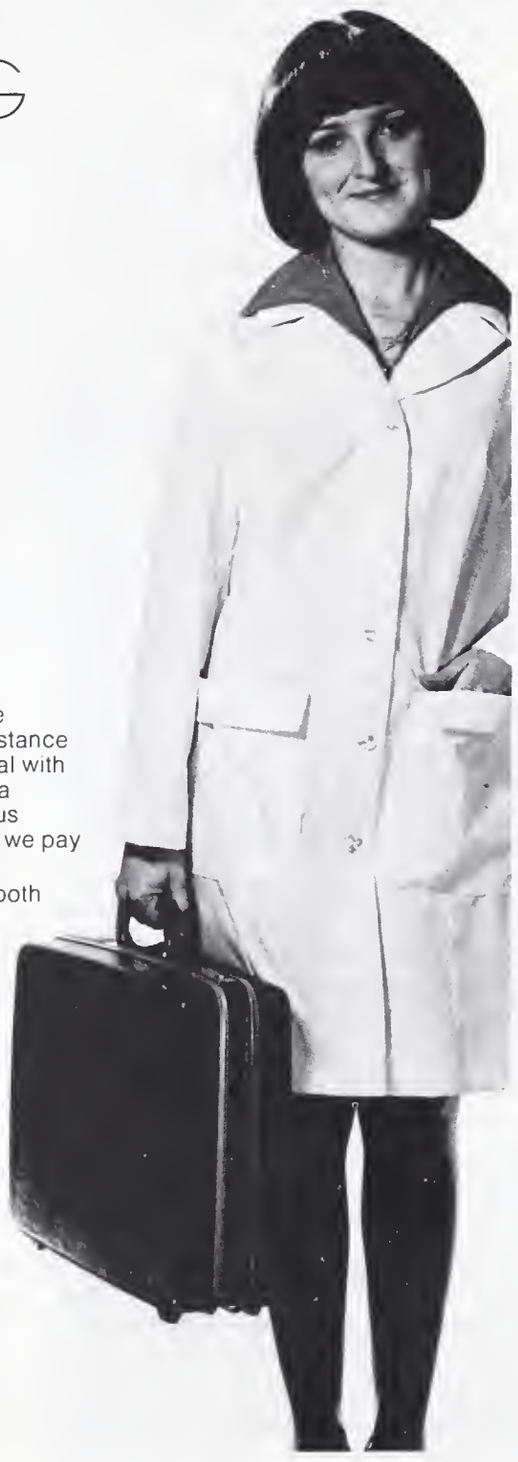
See over 4,000 samples in our newly remodeled carpet showroom from Karastan and other fine mills.

We specialize in Oriental rug cleaning and repairing.

K.A.Menendian
1090 West Fifth Avenue
294-3345



Your hospital's complete EEG laboratory!



Daneman Laboratories' space-age electronics technology and two long-distance telephone calls will provide your hospital with same-day EEG and ECHO readings by a qualified neurologist. Even instantaneous reports can be provided if needed. And we pay for the phone calls!

This service has wide benefits for both hospital and patient:

- Fully effective
- Safe and comfortable
- Professionally-administered
- Easily performed
- Inexpensive
- Fail-safe reporting procedures
- Already in operation nationwide

For a copy of our easy-to-understand, no-obligation proposal, please call or write Business Manager Jean Murphy.

Daneman Laboratories
P.O. Drawer 152, Gambier, OH 43022
Telephone. 614-427-4577

THE OHIO STATE Medical Association

Letters to the Editor

To the Editor:

In 1964, my report on 1,746 consecutive thyroidectomies was published in *The Ohio State Medical Journal.*[1] I wish to report that this series now includes 3,332 consecutive thyroidectomies without mortality at the end of 1977.

These 3,332 cases required various degrees of surgery — from subtotal to "total" thyroidectomy — to correct their thyroid pathology, but each case was individualized. Fluothane® was the anesthetic used in about 90% of the cases; 5% required endotracheal anesthesia. One patient developed hepatitis postoperatively, but it cleared completely. One patient had a temporary "cardiac arrest," recovered without trouble, but developed a heart murmur 15 years later. A third patient had a coronary occlusion and myocardial infarct enroute from surgery to the recovery room but is alive ten years postoperatively. The usual complication of damage to the recurrent nerve, hemorrhage, and hypoparathyroidism occurred numerically as reported in most series.

Review of the original article tends to show the same agreements and disagreements as originally stated.

As shown in the summary of the distribution of the types of goiter in 1964, random sampling can markedly change observed results unless the series is large. A smaller number of toxic smooth goiters are operated on, and surgery or radioactive iodine therapy rarely are needed on glands smaller than an estimated weight of 40 grams. Antithyroid medication usually will cause a prolonged remission or "cure" in smaller glands.

My article on the increase of thyroid cancer in Ohio from 1968 through 1970 was published in your *Journal* in 1971.[2] A summary of that article showed the incidence of carcinoma as being 12% in the three years reported, compared to the 5% previously reported. In the following seven years, the percentage has varied markedly: 5% in 1971; 14% in 1972; 9% in 1973; 6% in 1974; 23% in 1975; 17% in 1976; and 15% in 1977. This adds 39 cases of thyroid cancer to the 30 cases of cancer seen and proved surgically since 1968.

The classification of thyroid cancer still is dependent on the pathologist's diagnosis and still is extremely variable. Over this ten-year period of our observation, however, no deaths have resulted in those cases in which the pathologists did not all agree was obvious cancer. No deaths occurred in cases of the so-called "pathologist cancer."

It is felt that, regardless of its size, a cancer that is clinically significant and apparently growing should be considered a malignant lesion, treated as such, and not called "occult carcinoma," as it has been described previously. The term "small tumor" could be used for tumors smaller than 1.5 cm. Following adequate surgery, patients with these small tumors should be given suppressive doses of thyroid; they do not require radiation, either external or radioactive iodine.

/s/ John R. Sinkey, M.D.
Toledo, Ohio 43624

Generic and Trade Name of Drug
Halothane (Fluothane) Ayerst Laboratories

References

1. Sinkey JR: 1746 consecutive thyroidectomies without mortality. *Ohio State Med J* 60:670-671, 1964.
2. Sinkey JR: Increasing thyroid cancer in Ohio 1968 through 1970. *Ohio State Med J* 67:816-817, 1971.

* * * *

To the Editor:

In preparation for a September meeting of the National Institute of Allergy and Infectious Diseases to consider the feasibility and advisability of making the insect sting kit available to certain trained categories of medical and lay persons, without a specific prescription by a physician, I would be interested in receiving information and comments by the readers of this journal on the following questions:

1. Have you any knowledge of a fatal reaction to an insect sting or drug or food? If so, I would appreciate as much detail as possible, including information concerning the time interval between contact with the offending agent and death.
2. If you know of such a fatality or fatalities, in your estimation, would an immediate subcutaneous injection on the scene of a premeasured dose of epinephrine 1:1000 (0.3 to 1.5 cc for adult 0.2 to 0.3 cc for children) have afforded a different outcome?
3. Have you any knowledge of adverse effects of subcutaneous injections of epinephrine 1:1000 in the above dosages? If so, again I would appreciate as much detail as possible.

We would appreciate any information you can supply.

/s/ Claude A. Frazier, M.D.
Asheville, North Carolina
28801

The Ohio State Medical Association New Members

BELMONT (Bellaire)
Sugirthen Pandian

CLARK (Springfield)
Stephen Chun
Peter A. Erhardt

CRAWFORD (Galion)
Hooper Johnson

CUYAHOGA (Cleveland)
Robert T. Colacarro
Robert E. Hobbs
Junghae E. Kwon
Sergio J. Manubens
Jack H. Medalie
Esteban J. Saric

FRANKLIN
(Columbus unless noted)
Edward J. Baltes
Douglas P. Boldon, Worthington
John K. Brennan, Reynoldsburg
William Chinn
Marc Cooperman
Steven E. Gerald
Michael K. Haninger, Gahanna
Thomas H. Hartranft
Kiu Won Hwang
N. Timothy Jette
Stephen Ned Kolodzik
David C. Lee
Houshang E. Ma'ani
Edward W. Martin, Jr.
John E. Morcos
Timothy B. Moritz
J. Steven Polsley
Clifford W. Raymond, Westerville
Farrukh S. Sheikh
David G. Stockwell, Westerville
Philip M. Weinerman
Lawrence D. Weis
Joseph Paul Whitlatch
Frank W. Yoder
Judith E. B. Zacher

GREENE (Xenia)
Frank Lamont Jennings, Jr.
Muhammod A. Wirk

TREAT THE SYMPTOMS IN THE GERIATRIC PATIENT

APATHY • IRRITABILITY
FORGETFULNESS • CONFUSION



Cerebro-Nicin® CAPSULES

A GENTLE CEREBRAL STIMULANT & VASODILATOR FOR GERIATRIC PATIENTS

Each CEREBRO-NICIN capsule contains:
Pentylenetetrazole .....100 mg. • Nicotinic Acid ...100 mg.
Ascorbic Acid .....100 mg. • Thiamine HCl .....25 mg.
l-Glutamic Acid .....50 mg. • Niacinamide .....5 mg.
Riboflavin .....2 mg. • Pyridoxine HCl .....3 mg.
AVAILABLE: Bottles 100, 500, 1000
SIOE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and abdominal cramps. The reaction is usually transient.
INDICATIONS: As a cerebral stimulant and vasodilator.
RECOMMENOEO GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.
WARNING: Overdosage may cause muscle tremor and convulsions.
CONTRAINOICATIONS: Epilepsy or low convulsive threshold.
CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

Write for literature and samples . . .
BROWN THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057

HAMILTON (Cincinnati)
Andrew Deak
Gregory N. Entis
Roger W. Herman
Donald S. Jacobs
William C. Miller
Eva H. Riggenberg
Lester W. Sanders, III
Robert Smith
Sigmund R. Sugarman
Thomas E. Turek
Barbara Ann Warner

LICKING (Newark)
Jimmy Chanbonpin

LORAIN (Oberlin)
Harold Belizaire

LUCAS (Toledo unless noted)
Sunmi Yun Auh
Joel E. Borkow
Richard C. Gobeille
John T. Martin
T. W. Munro
Deirdre M. O'Connor
Harvey A. Popovich
Chan Soo Shon
Chinda Suriyapa, Oregon

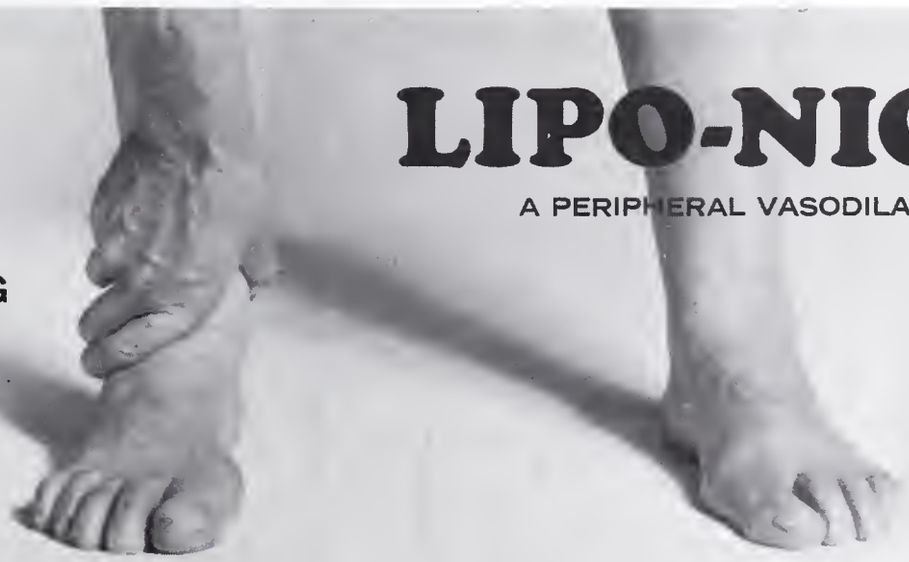
MARION (Marion)
Nelson H. Kraus

MONTGOMERY (Dayton)
Leon Cudkowicz
Joon Jae Lee
Stephen K. Rymer

SUMMIT (Akron unless noted)
William P. Boyd, Jr.
Timothy J. Myer, Cuyahoga Falls
Paul A. Steurer, Jr.
Ralph P. White

TUSCARAWAS (Uhrichsville)
Bharat Oza

COLD FEET
LEG CRAMPS
TINNITUS
DISCOMFORT ON STANDING



LIPO-NICIN
A PERIPHERAL VASODILATOR

IMMEDIATE or GRADUAL
nicotinic acid therapy

IMMEDIATE RELEASE

LIPO-NICIN/100 mg.
Each blue tablet contains:
Nicotinic Acid .....100 mg.
Niacinamide ..... 75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .. 25 mg.
Riboflavin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6).. 10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500, 1000.

LIPO-NICIN/250 mg.
Each yellow tablet contains:
Nicotinic Acid .....250 mg.
Niacinamide ..... 75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .. 25 mg.
Riboflavin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6).. 10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500, 1000.

GRADUAL RELEASE

LIPO-NICIN/300 mg.
Each time-release capsule contains:
Nicotinic Acid .....300 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (H-1) .. 25 mg.
Riboflavin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6).. 10 mg.
In a special base of prolonged therapeutic effect.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient. Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur. Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

BROWN THE BROWN PHARMACEUTICAL CO., INC. 2500 West Sixth Street, Los Angeles, California 90057
Write for Literature and Samples
REFER TO PDR

Workers' Compensation Bureau Clarifies Consultants' Services

Neil E. Webner

Physicians providing consultation for doctors treating industrial patients sometimes are unaware whether the Bureau of Workers' Compensation will make reimbursement for the consultation. Often, physicians do not know how to determine whether the consultation can be recognized in a workers' compensation case. The following information should clear up many issues. Answers to additional questions can be obtained by calling the Bureau's nearest district office or a special Bureau telephone service reserved for physicians (phone: 614/466-3652).

A physician should know if the Bureau actually recognizes the patient's industrial claim and if the conditions for which consultation is provided are among the recognized conditions in the claim. Also, consultations can be approved by the Bureau only upon referral by the physician recognized in the claim as the treating physician.

Is the Patient's Claim Recognized?

Assignment of a claim number does not necessarily mean that the claim is recognized. The treating physician or the patient can advise the consultant if claim payments were made to them. If none were made, you might contact the employer to inquire whether he disputes the claim, or the Bureau to determine if the claim is recognized.

If a patient's claim is disputed, several levels of administrative appeal might be employed to finally resolve the issues. However, further appeal will not stop payments for recognized treatments in a claim judged by a Regional Board of Review to be compensable.

Are the Conditions Recognized?

Simply stated, the Bureau may not pay for any treatment not specifically related to the recognized injury. After a claim application is filed, the patient will receive from the Bureau a computer-generated letter listing the alleged conditions and parts of body affected. A physician may request to see this letter, since it could help identify the conditions for which consultation can be paid.

Mr. Webner, Columbus, is Director of Public Affairs, Bureau of Workers' Compensation, State of Ohio.

However, the distinction between recognized and unrelated conditions can become cloudy in some cases. For example, a neurological consultation is recognized for head and brain injuries or an injury in which a state of depression is an allowed condition. Such consultations are also generally recognized for lower back injuries. If a physician has any reason to question whether the consultation he/she is about to provide relates to the recognized conditions, he/she should call the Bureau.

Is the Patient's Referring Physician Recognized as the Treating Physician?

The Bureau may not pay for services provided, referred by, or prescribed by other than the physician recognized in the patient's claim. This is ordinarily to prevent simultaneous treatment by more than one physician. When taking the patient's medical history, it would be helpful for a physician to know if the patient has seen any other physician within the last year. If so, request of the patient a copy of the Bureau's approval for a change of physician, or inquire by calling the Bureau.

In some instances, the Bureau could misinterpret a consultation as a treatment. In such event, the Bureau will send the physician a form C-35 explaining the disallowance of the fee bill. The consulting physician may indicate on the disallowance form that the fee bill was for consultation and not treatment. The annotated form should be returned to the Bureau.

Summary

The applicable rule guiding the Bureau's consideration of fees for consultation and requests for a change of physician is as follows:

> Medical fees shall not be approved for treatment by more than one physician for the same condition under the same period of time, except where a consultant, anesthesiologist or assistant is required, or where the necessity for treatment by a specialist is clearly shown and approved by the Bureau, by the Industrial Commission or its Medical Section, or in self-insuring employers, claims by the self-insured employer, in advance of such treatment, except in cases of emergency.

Finally, quicker payment can be expected if the fee bill is accompanied by a legible copy of the consultation report.

The Great Laxative Escape



COLACE®

dioctyl sodium sulfosuccinate

Colace means escape—from laxative stimulation, from laxative harshness, from laxative habit. Colace gently helps soften stools for easy, painless, unstrained elimination. It's the great laxative escape, from infancy to old age. Available in 100 and 50 mg. capsules. Syrup or liquid.

Mead Johnson
PHARMACEUTICAL DIVISION

©1978 Mead Johnson & Company • Evansville, Indiana 47721 U.S.A. 1578-1

This asthmatic isn't worried about his next breath...



he's active he's effectively maintained on

QUIBRON®

Each capsule or tablespoon (15 ml) elixir contains theophylline (anhydrous) 150 mg and glyceryl guaiacolate (guaifenesin) 90 mg. Elixir: alcohol 15%

- theophylline for effective around-the-clock bronchodilator therapy
- 100% free theophylline

Indications: For the symptomatic relief of bronchospastic conditions such as bronchial asthma, chronic bronchitis, and pulmonary emphysema.

Warnings: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other compounds containing xanthine derivatives concurrently.

Precautions: Use with caution in patients with cardiac disease, hepatic or renal impairment. Concurrent administration with certain antibiotics, i.e. clindamycin, erythromycin, troleandomycin, may result in higher serum levels of theophylline. Plasma prothrombin and factor V may increase, but any clinical effect is likely to be small. Metabolites of guaifenesin may contribute to increased urinary 5-hydroxyindoleacetic acid readings, when determined with nitrosonaphtol reagent. Safe use in pregnancy has not been established. Use in case of pregnancy only when clearly needed.

Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 μg/ml.

How Supplied: Capsules in bottles of 100 and 1000 and unit-dose packs of 100; Elixir in bottles of 1 pint and 1 gallon.

See package insert for complete prescribing information.

Mead Johnson

PHARMACEUTICAL DIVISION

©1978 Mead Johnson & Company • Evansville, Indiana 47721 U.S.A. MJL 6-4220R3

Colleagues in the News

ALBERT A. BRUST, M.D., Dayton, is the first person to be named to the Kettering Medical Center and Eugene W. Kettering Professorship of Clinical Medicine at Wright State University School of Medicine. The professorship honors the late Mr. Kettering, a Dayton-born engineer. Dr. Brust is Medical Residency Program Director and Director of the Medical Intensive Care Unit at Kettering Medical Center and Clinical Professor of Medicine at the School of Medicine.

LIBERATO J. A. DiDIO, M.D., Ph.D., Toledo, is the new President-Elect of the Ohio Academy of Science. Dr. DiDio is Dean of the Graduate School and Chairman and Professor of Anatomy, the Medical College of Ohio. The first faculty member appointed at the College, Dr. DiDio has received numerous honors including the Order of Merit in Medicine of the Republic of Brazil, the Andreas Vesalius Award presented by the Mexican Society of Anatomists, the Rorer Award of the American Society of Gastroenterology, and the Medal for Cultural Merit of the Republic of Italy.

JOHN C. GILLEN, M.D., Dayton, has been named Chairman of the Department of Family Practice, Wright State University School of Medicine. Having joined the department in 1975, Dr. Gillen most recently served as Acting Chairman, following the resignation of **DOUGLAS LONGENECKER, M.D.,** who returned to private practice. Prior to becoming a Wright State faculty member, Dr. Gillen practiced family medicine in southwest Ohio for nearly 20 years. He is a Fellow of the American Academy of Family Practice.

ROBERT W. KELLERMEYER, M.D., Cleveland Heights, has been appointed to the Myers Professorship for Hematology at Case Western Reserve University. Dr. Kellermeyer is Professor of Medicine in the School of Medicine and Codirector of the Division of Hematology at University Hospitals of Cleveland, Inc. He also serves as chairman of the newly formed Oncology Council, responsible for developing interdepartmental oncology functions at University Hospitals. Dr. Kellermeyer is a member of numerous national societies and is certified by the American Board of Internal Medicine in hematology and internal medicine.

SOLOMON LEVIN, M.D., has been appointed Chairman of the Council of Psychiatry for Northeastern Ohio Universities College of Medicine (NEOUCOM). He also will serve as Chairman of the Department of Psychiatry, Akron General Medical Center. Dr. Levin most recently served as Professor and Director of Postgraduate Education, School of Medicine at McMaster University, Hamilton, Ontario. He replaces **LOUIS D. KACALIEFF, M.D.,** Medical Director of the Akron Child Guidance Center, who participated in the organization of the Council.

ROBERT H. MAGNUSON, M.D., Columbus, has been honored by the Ohio Ophthalmological Association for 18 years service to the organization as secretary-treasurer. Dr. Magnuson received this honor during a meeting of the Ohio Ophthalmological Association held in conjunction with the 1978 OSMA Annual Meeting.

DAVID M. MONTGOMERY, M.D., Canton, won the 1978 Championship of the Ohio State Medical Golfers Association. A 13-handicapper, Dr. Montgomery led a field of 110 participants with a low gross of 74 strokes. Overall low net was won by **HARRY NEWLAND, M.D.,** Westerville, with a 79-19-60.

DAVID RUDY, M.D., Columbus, has been elected President of the Central Ohio Academy of Family Physicians for 1979. Dr. Rudy is a member of the Medical Staff of Riverside Methodist Hospital.

JOHN M. TEW, JR., M.D., Cincinnati, has been elected President of the Ohio State Neurosurgical Society. Other officers are **MARK RAYPORT, M.D.,** Toledo, president-elect; **RUSSEL THOMAS, M.D.,** Akron, vice-president; **RUSSEL HARDY, M.D.,** Cleveland, secretary; and **ALBERT TIMPERMAN, M.D.,** Mansfield, treasurer.

VICTOR VICTOROFF, M.D., Cleveland, has received the first Ohio Psychiatric Association Distinguished Service Award for "outstanding contributions as a clinician, writer and researcher." Dr. Victoroff is Chief of the Division of Psychiatry, Huron Road Hospital.

"Colleagues in the News" is sponsored by

Blue Shield
Ohio Medical Indemnity, Inc.

6740 North High Street, Worthington, Ohio 43085

(614) 438-3500

(PAID ADVERTISEMENT)

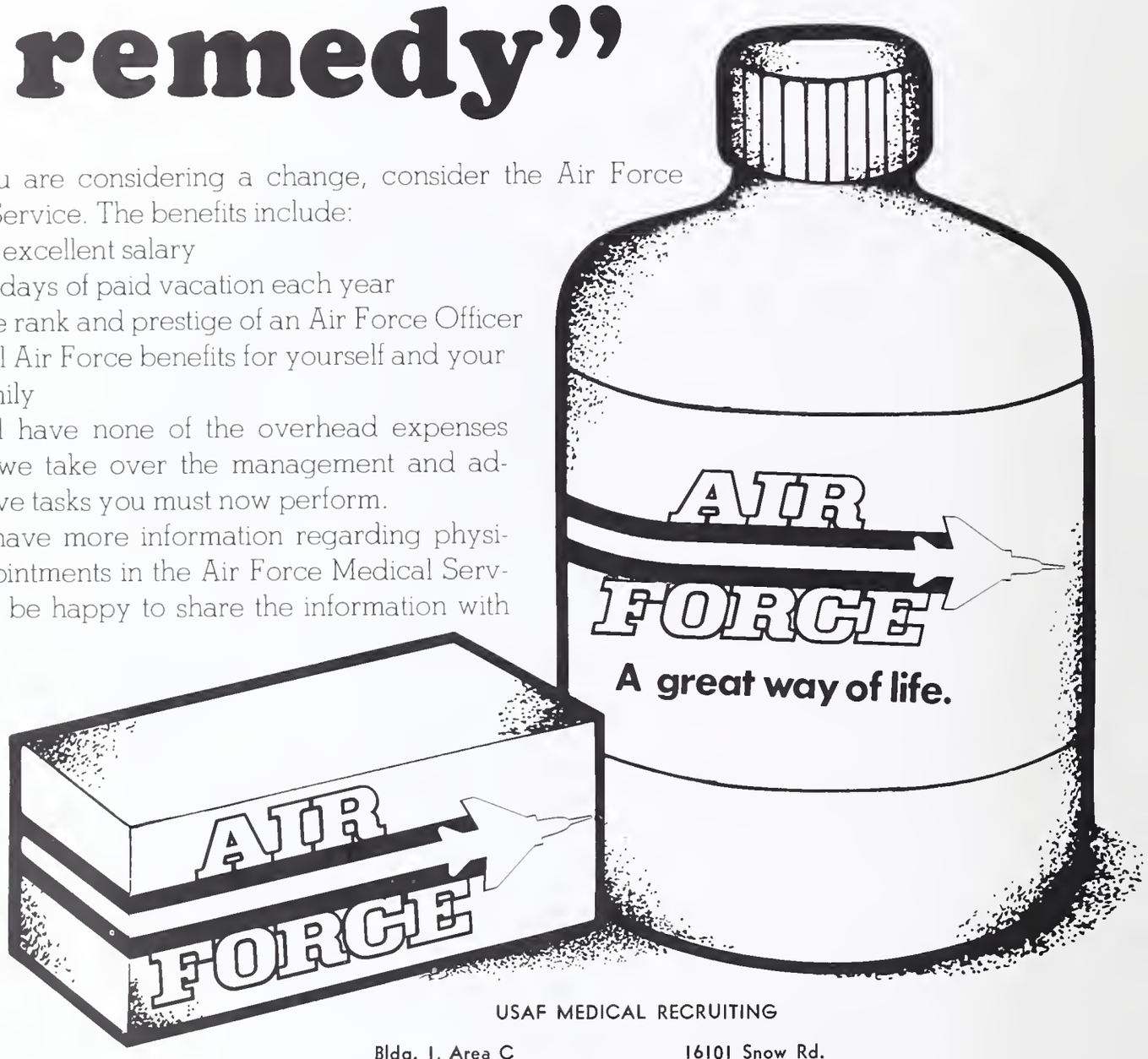
"We've got the remedy"

If you are considering a change, consider the Air Force Medical Service. The benefits include:

- An excellent salary
- 30 days of paid vacation each year
- The rank and prestige of an Air Force Officer
- Full Air Force benefits for yourself and your family

You'll have none of the overhead expenses because we take over the management and administrative tasks you must now perform.

We have more information regarding physician appointments in the Air Force Medical Service. We'll be happy to share the information with you.



USAF MEDICAL RECRUITING

Contact:

Bldg. 1, Area C
Wright-Patterson AFB
Ohio 45433
Phone: 513/257-7442

16101 Snow Rd.
Suite 300
Cleveland, Ohio 44142
Phone: 216/522-4325

Air Force. A great way of life.

Legislative Update

the federal scene

(Courtesy the AMA Washington Office and OSMA Department of Federal Legislation)

AMA Expresses Grave Concern Over Department of HEW's Certificate-of-Need Plans

The American Medical Association took strong exception June 29 to criteria proposed for certificate-of-need regulation by health systems agencies and state agencies.

In a statement filed with the Bureau of Health Planning and Resources Development, U.S. Department of Health, Education and Welfare, AMA Executive Vice President James H. Sammons, M.D., expressed grave concern over the proposed regulations ("Health Systems Agency and State Agency Review of the Appropriateness of Existing Institutional Health Services and of Proposed New Institutional Health Services," *Federal Register,* 21274, May 16, 1978).

Dr. Sammons stressed that the mandated criteria would limit flexibility of local agencies in meeting their communities' health needs.

In addition to a general statement of concern in regard to the overall regulations, the AMA submitted the following statement specifically dealing with certificate-of-need criteria for health systems agencies and the state health planning and development agencies (SHPDAs):

The Notice of Proposed Rulemaking of May 16, 1978, on appropriateness review also contains changes to the proposal of March 17, 1978, relating to the criteria to be used by Health Systems Agencies (HSAs) and State Health Planning and Development Agencies (SHPDAs) during certificate of need (CON) review.

Specifically, these changes would (1) amend the definition of new institutional health services subject to review; (2) add new criteria for such review; and (3) change the findings that must be made before a CON may be issued.

The American Medical Association is particularly concerned about the amended definition of new institutional health services subject to review. Under this revision, CON would be required when there is: "A change in the bed capacity of a health care facility or health maintenance organization which increased the total number of beds (or distributes beds among various categories, or relocates such beds from one physical facility or site to another) by more than 10 beds or more than 10% of total bed capacity as defined by the State, whichever is less, over a 2-year period."

As we interpret this proposal, a CON would be required for almost any change in bed distribution within an institution. A shift of 10 hospital beds over a two year period can hardly be called a "major" change justifying the time and expense of a CON proceeding. In fact, the procedural costs of seeking the CON could exceed the expenditures involved in changing the bed capacity. We believe that such close regulation would only add to the costs of hospital care, not help to restrain it.

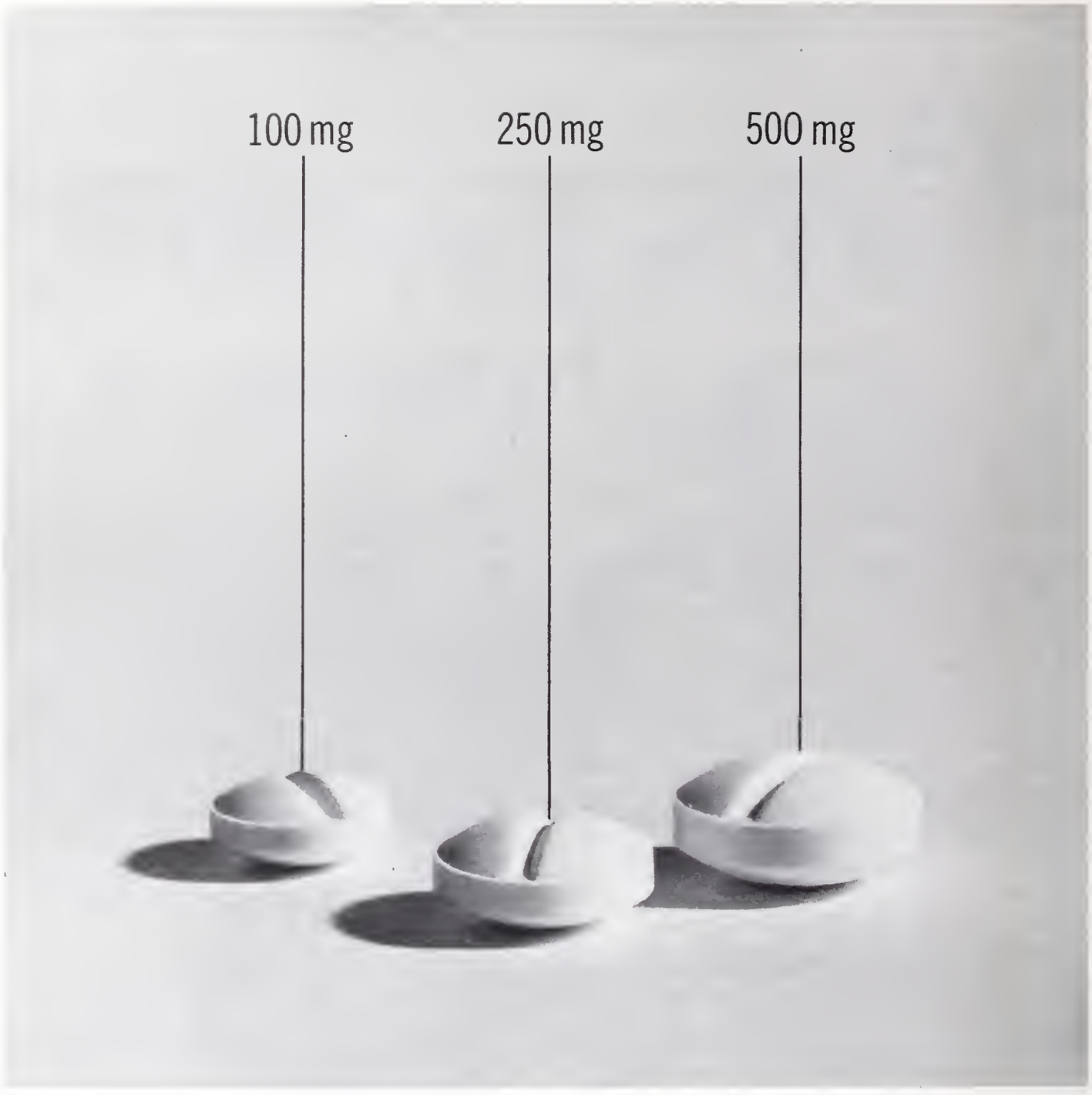
This proposal also could inhibit flexible management of health care facilities by subjecting even minor decisions to the regulatory process. Flexibility in management is essential if institutions are to respond quickly to changing circumstances, i.e. staff shortages, natural disasters or other major emergencies, or changes in the health needs of the population served by the institution. To subject almost all decision making to a cumbersome CON process could adversely affect the quality and availability of health care to patients.

We believe that CON should be required for changes in bed capacity only when the cost of the changes exceeds the dollar threshold for other capital expenditures ($150,000 or less if specified by state law).

One of the proposed new criteria for CON would be the contribution of the proposed health service in meeting the health needs of minorities, women and handicapped individuals in the service area. We believe that these criteria are so vague as to be extremely difficult to administer. For example, how would an HSA reconcile a minority's specific health need with the national guidelines which are broad standards based on national averages? The health planning law imposes on HSAs and SHPDAs enough complex burdens without HEW's having to add any more.

We also question the appropriateness of HEW's setting out with such specificity the findings that must be made before a CON can be issued. We believe that for the federal government to delineate so strictly the actions of HSAs and SHPDAs is contrary to effective and responsible local health planning. We recommend that these requirements be eased so that state and local agencies can have greater flexibility in their decision making and be able to respond properly to the health needs of their local populations.

In conclusion, we believe that health planning will be more effective if central federal control is diminished in favor of greater local control. These proposed changes to the standards for CON should be revised to encourage responsibility and initiative on the part of state and local planning agencies.



Tolinase®
tolazamide, Upjohn

Please contact your Upjohn representative for additional product information.

Upjohn

J-5695-6

©1977 THE UPJOHN COMPANY

The Ohio Medical Association Continuing Education Programs

Editor's Note: *The following are Category I courses offered in Ohio. Items for this listing come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in dates, places, or time occur too late to be corrected before publication. Physicians interested in a course are urged to contact the sponsoring organization to confirm the information listed. Sponsoring organizations may list Category I courses by contacting the OSMA Department of Continuing Medical Education or The Journal. Notification 90 days prior to the course would be appreciated. Due to space limitations, announcements may be published only once.* **See previous issues of The Journal for additional courses.**—*L.A.J.*

August 1978

TUMOR CONFERENCE: July 13, July 15, August 10, August 12, September 14, September 16; St. John's Hospital, Cleveland; 1 credit hour each session; contact: M. S. Farooqi, M.D., Director of Medical Education, St. John's Hospital, 7911 Detroit Avenue, Cleveland 44102, phone: 216/651-7000, ext. 394.

September 1978

NUTRITION— MEDICINE'S NEW FRONTIER: September 8-9; Mount Carmel Medical Center, Columbus; 8½ credit hours; fee: $5, no fee for students or physicians-in-training; contact: William R. Hughes, Ph.D., Director of Education, Mount Carmel Medical Center, 793 West State Street, Columbus 43222, phone: 614/225-5178.

NUTRITION AND LIPOSURGERY: September 9-10; Stouffer's Dayton Plaza Hotel, Dayton; 12 credit hours; fee: $85, $65 faculty; contact: Arlene L. Polster, Wright State University, Dept. of PMCE, P.O. Box 927, Dayton 45401, phone: 513/372-7140.

SYMPOSIUM ON RENAL AND UROLOGIC DISEASE IN CHILDREN: September 13; Cleveland Clinic Foundation, Cleveland; 4 credit hours; fee: $15; contact: Director of CME, The Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

GYNECOLOGICAL INFECTIONS AND ANTIBIOTIC USAGE, INCLUDING POSTSURGICAL INFECTION: September 14; Community MedCenter Hospital, Marion; guest speaker: Dr. Norman K. Cooperman, Dept. of Obstetrics and Gynecology, Cook County Hospital, Chicago; 1 credit hour; contact: Robert R. Tracht, Administrator, 1050 Delaware Ave., Marion 43302, phone: 614/387-8604.

ANNUAL JOINT MEETING OF THE OHIO CHAPTER, AMERICAN COLLEGE OF PHYSICIANS AND OHIO SOCIETY OF INTERNAL MEDICINE: September 14-16; Stouffer's University Inn, Columbus; 11 credit hours; fee: $40, $25 members; contact: Vickey McVay, Organization Services Coordinator, Ohio Society of Internal Medicine, 600 S. High St., Columbus 43215, phone: 614/228-6971.

CLINICAL PHARMACOLOGY: September 20, Sheraton Dayton Downtown, Dayton; sponsor: Wright State University School of Medicine; 5 credit hours; fee: $30, $20 WSU faculty, no fee WSU residents and medical students; contact: Arlene L. Polster, Wright State University School of Medicine, Dept. of PMCE, P.O. Box 927, Dayton 45401, phone: 513/372-7140.

CURRENT PROBLEMS IN GYNECOLOGY: September 20, Cleveland Metropolitan General Hospital, Cleveland; sponsor: Cleveland Metropolitan General Hospital; cosponsor: Case Western Reserve University; 7 credit hours; contact: Mortimer G. Rosen, M.D., Cleveland Metropolitan General Hospital, Department of Obstetrics and Gynecology, 3395 Scranton Rd., Cleveland 44109, phone: 216/398-6000, ext. 4261.

UPDATE ON THYROID OR OTHER ENDOCRINE DISORDERS: September 20 and 21; The Cleveland Clinic Foundation, Cleveland; 12 credit hours; fee: $100, $50 physicians-in-training; contact: Director of CME, The Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

39TH ANNUAL MEETING OF OHIO SOCIETY OF ANESTHESIOLOGISTS, INC.: September 22-24; Hilton Inn North, Columbus; sponsor: OSMA/Ohio Society of Anesthesiologists; 9 credit hours; fee: no fee members, $30 nonmembers, $15 nonmember allied health personnel; contact: Vickey McVay, Organization Services Coordinator, Ohio Society of Anesthesiologists, Inc., 600 S. High St., Columbus 43215, phone 614/228-6971.

October 1978

1978-1979 CORE CONTENT REVIEW OF FAMILY MEDICINE: October 1978-May 1979 (monthly correspondence course); sponsor: Ohio Academy of Family Physicians; cosponsor: Connecticut Academy of Family Physicians; 32 credit hours; fee: $55 AAFP member, $75 nonmember, $25 FP residents in groups of four or more; contact: Florence I. Landis, Executive Director, Ohio Academy of Family Physicians, 4075 N. High St., Columbus 43214, phone: 614/267-7867.

FOURTH ANNUAL OBSTETRICS/GYNECOLOGY SYMPOSIUM: October 1-4; Key Biscayne Hotel, Key Biscayne, Florida; sponsor: Wright State University School of Medicine, Dept. of Obstetrics-Gynecology; 14 credit hours; fee: $200, $160 WSU faculty; contact: Arlene L. Polster, Wright State University, Dept. of PMCE, P.O. Box 927, Dayton 45401, phone: 513/372-7140.

TUMOR CONFERENCE: October 12, October 14; St. John Hospital, Cleveland; 1 credit hour each session; contact: M. S. Farooqi, M.D., Director of Medical Education, St. John Hospital, 7911 Detroit Ave., Cleveland 44102, phone: 216/651-7000.

INTRODUCTION TO ELECTROPHYSIOLOGIC ASSESSMENT OF THE AUDITORY SYSTEM: October 13-14; The Cleveland Clinic Foundation, Cleveland; 14 credit hours; fee: $200, $150 physicians-in-training; contact: Center for COME, The Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106, phone: 216/444-5696.

Practice Productivity Inc.

Cosponsored by the

Ohio State Medical Association

ONE DAY WORKSHOP

BUSINESS ESSENTIALS FOR A MEDICAL OFFICE

FOR YOUR MEDICAL OFFICE ASSISTANTS

8:45 a.m. to 5:00 p.m.

Oct. 17, 1978	Toledo	Sheraton-Westgate Inn
Oct. 18, 1978	Cleveland	Marriott Inn - Airport
Oct. 19, 1978	Akron	Tangier Restaurant
Oct. 24, 1978	Columbus	Marriott Inn
Oct. 25, 1978	Dayton	Imperial Crown Dayton
Oct. 26, 1978	Cincinnati	Marriott Inn
Oct. 31, 1978	Lima	Ramada Inn
Nov. 1, 1978	Canton	Sheraton Belden Inn
Nov. 2, 1978	Youngstown	Howard Johnson's Motor Lodge

OFFICE MANAGERS
RECEPTIONISTS
MEDICAL SECRETARIES
BOOKKEEPERS
INSURANCE CLERKS
NURSES

This program has been approved for Continuing Education Units by AAMA

TOPICS: Telephone Management, Appointment Scheduling, Medical Records, Personnel, Billing Systems and Collection, Insurance Claim Processing.

Practice Productivity Inc. is a national management consulting firm located in Atlanta whose only clients are physicians engaged in the private practice of medicine. Practice Productivity offers educational and motivational workshops in sound business concepts to physicians, medical office managers, and medical assistants. Practice Productivity also provides nation-wide individual consulting to physicians at their private practice.

For Further information, contact:
Duane M. Johnson, PhD, Executive Vice-President, Practice Productivity, Inc.

Registration Form

Name	Position	City Will Attend	Date Will Attend
1.			
2.			
3.			

Name of Practice: _____

Specialty: _____ Telephone: (_____) _____

Address: _____

City: _____ State: _____ Zip: _____

Full tuition fee of $ _____ is enclosed at $75 per registrant. Tuition includes course materials and luncheon and MUST ACCOMPANY THIS FORM. (There is a $10 handling fee deducted on all refunds for cancellations received at least one week in advance of course; no refund thereafter.)

Practice Productivity Inc.

2000 Clearview Avenue, Atlanta, Georgia 30340, Telephone (404) 455-7344 or Toll Free 800-241-6228

THE OHIO STATE Medical Association Obituaries

HENRY L. ABBOTT, M.D., Tiffin; Northwestern University Medical School, Chicago, 1943; age 61; died June 8; member OSMA and AMA.

NACI A. AKLAR, M.D., Springfield; Tip Fakultesi Istanbul Universitesi, Istanbul, Turkey, 1952; age 51; died 1977; member OSMA and AMA.

JOHN T. CRONE, M.D., Milford; University of Arkansas School of Medicine, Little Rock, 1935; age 69; died May 26;

MARVIN FISH, M.D., Columbus; Vanderbilt University School of Medicine, Nashville, Tennessee, 1951; age 59; died May 25; member OSMA and AMA.

JOSEPH GAGLIONE, M.D., Cleveland; St. Louis University School of Medicine, St. Louis, Missouri, 1949; age 54; died May 22; member OSMA and AMA.

MORRIS E. GANS, M.D., Cleveland; Ohio State University of Homeopathic Medicine, 1918; age 85; died June; member OSMA and AMA.

CIRIL GOSTIC, M.D., Cleveland; Medizinische Fakultat der Ludwig-Maximiliams-Universtat, Munchen, Bayern, Germany, 1953; age 54; died June; member OSMA and AMA.

ALEXANDER HOFFMEISTER, M.D., Cleveland; Case Western Reserve University, 1921; age 90; died June 8; member OSMA and AMA.

RALPH S. HOSLER, M.D., Ashville; Ohio State University College of Medicine, 1912; age 89; died May 22; member OSMA and AMA.

DALE D. HUBBARD, M.D., Holbrook, Arizona; Ohio State University College of Medicine, 1954; age 54; died May 24; member OSMA and AMA.

R. FRANKLIN JUKES, M.D., Winter Haven, Florida; Ohio State University College of Medicine, 1926; age 82; died May 18; member OSMA and AMA.

ANTON J. JUNG, M.D., Dayton; Medicinski Faktultet Sveucilista u Zagrebu, Zagreb, Yugoslavia, 1939; age 71; died May 3; member OSMA and AMA.

KARL P. KLASSEN, M.D., Columbus; University of Chicago Pritzker School of Medicine, Chicago, 1936; age 69; died May 17; member OSMA and AMA.

JOHN S. SCHLECHT, M.D., Nokomis, Florida; Case Western Reserve University School of Medicine, 1950; age 55; died April 28; member OSMA and AMA.

CHARLES J. SILVA, M.D., Medina; Ohio State University College of Medicine, 1952; age 58; died June 6.

JOHN F. STOTLER, M.D., Youngstown; Rush Medical College, Chicago, 1940; age 62; died June 21; member OSMA and AMA.

FRANK S. VAN DYKE, M.D., Elyria; Ohio State University College of Medicine, 1914; age 91; died April 7; member OSMA and AMA.

HASHMET YALAZ, M.D., Springfield; Tip Fakultesi Ankara Universitesi, Ankara, Turkey, 1946; age 56; died 1977; member OSMA.



WINDSOR HOSPITAL

A NONPROFIT CORPORATION

— ESTABLISHED 1898 —

Chagrin Falls, Ohio

247 - 5300

A hospital for the treatment of Psychiatric Disorders

High on a Hill-Top, Overlooking Beautiful Chagrin River Valley.

Accredited by Joint Commission on Accreditation of Hospitals.

Booklet available on request.

FRIEDRICH A. LINGL, M.D. Medical Director

GUY H. WILLIAMS, JR., M.D. Medical Director Emeritus

HERBERT A. SIHLER Jr. President

MEMBER: American Hospital Association—National Association of Private Psychiatric Hospitals

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

When **impotence** is due to androgenic deficiency.

Android® /5 mg. Buccal/ /10 mg. Oral /25 mg. Oral

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric/eunuchoidism, eunuchism/post-puberal cryptorchidism.



Write for new double-blind study reprints and samples.

BROWN **THE BROWN PHARMACEUTICAL CO., INC.**
2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

Report on the 1978 Annual Meeting of the American Medical Association

H. William Porterfield, M.D., Delegate
Linda A. Porterfield, Executive Editor

The Ohio Delegation arrived in St. Louis on June 16 for the 1978 Annual Meeting of the American Medical Association. Those in attendance were Delegates John E. Albers, M.D., Cincinnati; George N. Bates, M.D. Toledo; Oscar W. Clarke, M.D., Gallipolis; Jerry L. Hammon, M.D., West Milton; W. J. Lewis, M.D., Dayton; H. William Porterfield, M.D., Columbus; P. John Robechek, M.D., Cleveland; Jack Schreiber, M.D., Canfield; and Robert N. Smith, M.D., Toledo. The Alternate Delegates were Theodore J. Castele, M.D., Cleveland; Stewart B. Dunsker, M.D., Cincinnati; C. Douglass Ford, M.D., Toledo; Thomas E. Fox, M.D., Mason; Richard L. Fulton, M.D., Columbus; John .J. Gaughan, M.D., Cleveland; Edward E. Grable, M.D., Canton; B. Leslie Huffman, Jr., M.D., Maumee; and Robert G. Thomas, M.D., Elyria.

John H. Budd, M.D., Cleveland, concluded his term as President of the AMA at this meeting. As usual, he gave an inspired address at the opening session (See text this issue.) ; and he should be commended for his thoughtful leadership this past year.

The House of Delegates also passed two resolutions in memory of Ohioans who had died since the 1977 Interim Meeting. Those honored were Henry A. Crawford, M.D., Cleveland, delegate to the AMA; and John W. Moses, M.D., Akron, member of the Council on Medical Education.

Most of Saturday, June 17, was devoted to a review of the more than 300 resolutions and reports which were to be discussed and acted on during this session. The highlight of the entire meeting was the careful review of the 48 recommendations contained in the report of the National Commission on the Cost of Medical Care. This Commission was evolved by the AMA Board of Trustees to carry out an indepth study of the cost of medical care. The report to the Board of Trustees and the House of Delegates for their consideration represented a summary of the Commission's findings.

The Commission was composed of individuals from labor, management, and the insurance and hospital industries, and economists and physicians. The Commission was chaired by AMA Past President Max H. Parrott, M.D. A detailed analysis of the report of the National Commission on the Cost of Medical Care was rendered by the AMA Board of Trustees. This analysis contained comments and recommendations regarding the 48 specific items. At the June meeting, these items were divided among the various reference committees for thorough discussion and a report to the House for final action. As expected, some of these recommendations were accepted by the House, some were questioned and referred back to the Board of Trustees for further study, and others were contested vigorously but, likewise, were sent back for further study and evaluation before final action.



LEFT TO RIGHT: AMA President John H. Budd, M.D., Cleveland, congratulates his newly installed successor, Tom E. Nesbitt, M.D., Tennessee. (Photograph by Joe Fletcher, AMA Staff.)

The Ohio Delegation devoted Sunday morning, June 18, to hearing the various candidates seeking the office of AMA President-Elect or a spot on the Board of Trustees. Between campaign presentations, further attention was given to the proposed reports and resolutions.

(continued on page 516)



LEFT TO RIGHT: Robert B. Hunter, M.D., Chairman of the AMA Board of Trustees, presents the Scientific Achievement Award to F. Mason Sones, M.D., Cleveland. (Photograph by Joe Fletcher, AMA Staff.)

Awards

The House of Delegates convened at 2 PM on Sunday, June 18, with a call to order by Speaker William Y. Rial, M.D., Pennsylvania. Following the ceremonial aspects of the opening session, a number of special awards and citations were given. Of special interest to Ohioans was the Scientific Achievement Award, which was presented to F. Mason Sones, M.D., Cleveland. This award is made only on special occasions to a physician or nonphysician selected by the Board of Trustees in recognition of outstanding work. Dr. Sones has been instrumental in the development of new and improved techniques for exploring the heart with special catheters and defining the morphology of the central circulation using high-speed x-ray motion picture photography known as cine cardioangiography.

Ohio also received an award from the American Medical Political Action Committee (AMPAC) in recognition of the achievement of having its entire AMA Delegation, OSMA president and president-elect, and PAC chairman as sustaining members ($100 contributors) of AMPAC.

Unfinished business carried over from the 1977 Interim Meeting involved the new *Principles of Medical Ethics* as proposed by the Judicial Council. The OSMA House of Delegates approved the revised Principles in May. The Judicial Council requested that these Principles be referred back and that a joint committee composed of members of the House of Delegates and the Judicial Council meet to resolve the remaining problems and present a final report for adoption at the 1978 Interim Meeting.

Elections

The last session of the House of Delegates, held Thursday, June 22, saw the election of Trustee Hoyt D. Gardner, M.D., Louisville, Kentucky, to the position of president-elect. Those incumbant trustees up for election were reelected to their positions, and the two vacancies on the Board were filled by William S. Hotchkiss, M.D., Virginia, and George A. Rowland, M.D., Pennsylvania. In addition, Ohio's John R. Beljan, M.D., Dean, Wright State University School of Medicine, was elected to the Council on Scientific Affairs.

Reference Committee on Amendments to Constitution and Bylaws

At the 1977 Interim Meeting, the House of Delegates established guidelines for accepting organizations for representation in the House. In addition to the specialty societies which qualified under those guidelines, the Board of Trustees recommended the seating of the following organizations: American Geriatric Society, American Society for Clinical Pharmacology and Therapeutics, Congress of Neurological Surgeons, and Society of Medical Consultants to the Armed Forces. The House concurred, and delegates from these organizations were seated.

The Council on Constitution and Bylaws presented their final decimalization of the AMA Bylaws. The presentation finalized this complex task which has been on going for several years. The House adopted the decimalization.

The House also approved the seating of a resident representative on the Council on Constitution and Bylaws. This person will be elected by the House of Delegates and will have full voting privileges. The Council has recommended reorganization of the AMA Student Business Session, and this reorganization was accepted by the House. Both the students and the resident group have made major and significant contributions to the House of Delegates since being seated several years ago.

★ Recommendation No. 5 in the Report of the National Commission on the Cost of Medical Care pertained to regional physician and hospital directories. This recommendation was referred to the Board of Trustees for further study and recommendation because although the House recognized that some form of basic directory is appropriate, the details of information to be provided need to be resolved.

Reference Committee A Insurance and Medical Service

Ohio Delegate W. J. Lewis, M.D., Dayton, chaired this Committee, which was presented with an enormous

(continued on page 518)

★Recommendation contained in report of the National Commission on the Cost of Medical Care.
†Resolution sent to the AMA House of Delegates by Ohio.

Harding Hospital

ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

MEMBER BLUE CROSS OF CENTRAL OHIO

ADMISSION AND PRACTICES CONDUCTED WITHOUT REGARD TO RACE, CREED, OR NATIONAL ORIGIN

Offering a Full Range of Psychiatric Services

★ Inpatient Services for 120
★ Individual and Group Psychotherapy
★ Professional Adjunctive Therapy
★ Family Therapy
★ Special Care for the Disturbed Patient
★ Day Treatment for Adults and Adolescents
★ Halfway House
★ Family Care
★ Outpatient Treatment
★ Consultation and Evaluation
★ Special Program for Adolescents, Including School

For further information, call (614) 885-5381

George T. Harding, Jr., M.D.
Medical Director

Donald L Hanson
Administrator

445 East Granville Road
Worthington, Ohio 43085

IMMKE CIRCLE LEASING INC

Endorsed Leasing Company
Of The Ohio State Medical Association

Immediate delivery on many 1978 models

We lease all foreign and domestic makes and models including Mercedes, Jaguar, Porsche, etc.

Many people think of leasing as just automobiles.
We do that too, but, in addition, we want to lease you any professional equipment.

Immke Circle Leasing, Inc.
32 South Fifth Street
Columbus, Ohio 43215

Telephone 614-228-1701 or Toll Free 1-800-282-0256

amount of work including 16 of the recommendations of the Commission on the Cost of Medical Care, a host of reports from the Board of Trustees and Council on Medical Service, and numerous individual resolutions. The Reference Committee was in open session for eight hours and in executive session nearly as long to draft their report.

Medicaid Provider Agreement

★ Report A of the Council on Medical Service dealt with the Medicaid provider agreement. This report was stimulated by the Ohio resolution submitted at the 1977 Interim Meeting, in which Ohio requested that the AMA pursue an educational campaign to inform members of the provisions and the applications of Title 19 and the provider agreement to the physician's own practice. In addition, the Ohio resolution requested that the AMA "introduce and support legislation in Congress to remove the use of a 'provider agreement' as a requirement for participation under Medicaid."

Many state agencies have additional requirements in their Medicaid programs beyond the federal requirements. Federal law and regulations require a physician to keep records and to disclose information on Medicaid recipients, to avoid discrimination, and to accept Medicaid payment as payment in full.

Ohio's concern was that, under the provider agreement, the Department of Public Welfare would allow the state agency to audit the claim records of private as well as Medicaid patients to insure comparability of charges. AMA legal counsel reported that a provider agreement merely formalizes legal rights to review records related to Medicaid claims and that in order to examine records of private patients, the state would have to show cause and to obtain subpoenas if a physician wished to refuse such examination. It should be noted that the physician's customary charges to private patients are on file with the local Medicare carrier.

The AMA Councils on Medical Service and on Legislation both felt that the Ohio request for an education campaign and for deletion of the mandatory provider agreement were impossible tasks and were inconsistent with the AMA's longstanding advocacy of fiscal responsibility in federal programs.

National Commission Recommendations

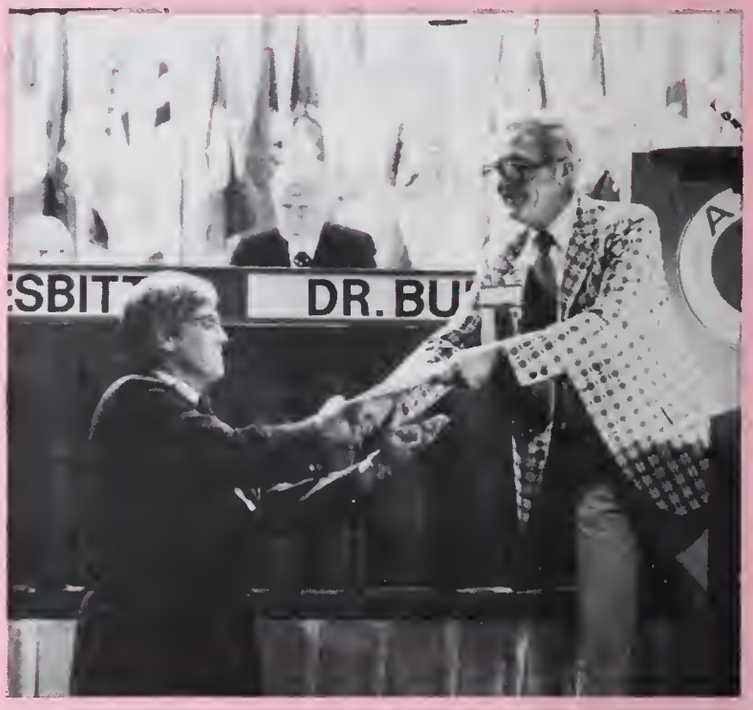
★ Recommendation No. 1 of the Commission on the Cost of Medical Care concerned economic incentives for purchase of insurance and health plans. This recommendation was endorsed by the Board of Trustees and approved by the House. In addition, the House passed a substitute resolution which opposes the current Presidential recommendation that would increase the medical expense deduction exclusion from 3% to 10% for Internal Revenue Service purposes.

★ Recommendation No. 2 encourages consumer cost-sharing in medical care expense. This concept was endorsed by the Board of Trustees and was approved by the House of Delegates.



W. J. Lewis, M.D., Dayton, Chairman, Reference Committee A. (Photograph by L.A.P.)

★ Fair market health plan competition was the subject of Recommendation No. 3. The House approved the concept of neutral public policy and fair market competition among all systems of health care delivery, including health maintenance organizations (HMOs), fee-for-service practices, and other provider and insurance systems. The House referred this matter to the Board of Trustees for an objective assessment of HMOs, including independent practice associations (IPAs) and other group arrangements.



LEFT TO RIGHT: H. William Porterfield, M.D., Columbus, Chairman of the Ohio Medical Political Action Committee, receives a membership award on behalf of OMPAC from Rex E. Kenyon, M.D., Oklahoma, Chairman, American Medical Political Action Committee. (Photograph by Joe Fletcher, AMA Staff.)

★ Reimbursement levels for providers was the subject of Recommendation No. 9. It calls for local groups, composed of physicians, hospital administrators, third-party payors, and other appropriate parties, to determine whether levels of reimbursement for providers are reasonable. The House reaffirmed existing AMA policy that states:

> Physicians should volunteer fee information and, where the circumstances permit, fees should be discussed with the patient in advance of services. Ability to pay should be considered in reducing usual and customary charges. The use of uniform fee schedules should be opposed.

Fees

★ The need for private and government insurance benefit packages to be adjusted to provide balanced coverage of alternative services and settings in the provision of health care was covered in Recommendation No. 15. In addition, this recommendation calls for these benefit packages to restrict reimbursement for health services provided in inappropriate settings. The House referred this item to the Board of Trustees for further evaluation.

Two resolutions relating to this topic dealt with the payment for services rendered in physicians' offices. The House adopted the following statement:

> RESOLVED, That the American Medical Association urge the Health Insurance Association of America and the Blue Cross/Blue Shield Association to refrain from providing policies which penalize patients for selecting their physician's offices for performance of medical and surgical procedures.

Michigan submitted a resolution regarding the study of fee regionalization. They requested that the AMA study the appropriateness of regionalization of fees on a national level. This resolution was recommended for adoption by the Reference Committee but was defeated by the House.



LEFT TO RIGHT: Oscar W. Clarke, M.D., Gallipolis, Vice-Chairman of the Ohio Delegation; and P. John Robechek, M.D., Cleveland, Chairman of the Ohio Delegation. (Photograph by L.A.P.)



LEFT TO RIGHT: OSMA President John J. Gaughan, M.D., Cleveland, and George H. Franck, M.D., Cleveland, Delegate from the American Academy of Occupational Medicine. (Photograph by L.A.P.)

Another resolution regarding payment was one submitted by the Illinois Medical Society which opposed any insurance company policy rider giving the insurance company the power of decision as to medical necessity of services over and above the judgment of the treating physician. This resolution arose due to a recent Illinois Blue Cross/Blue Shield rider. The House of Delegates reaffirmed previous policy by stating:

> RESOLVED, That the AMA urge all health insurance carriers and government health care financing agencies to rely on appropriate medical peer review programs for adjudication and resolution of all matters concerning the quality or utilization of medical services which require professional judgment; AND BE IT FURTHER
>
> RESOLVED, That peer review programs shall have as their goal both improved quality of medical care and more efficient delivery of medical services.

★ Recommendation No. 41 concerned reimbursement for allied health personnel. It stated that reimbursement systems should pay physicians or their institutions directly for the services of allied health personnel. These professionals should be under the supervision of practicing physicians. The Board of Trustees endorsed this recommendation, and the House concurred.

Second Opinions

★ Recommendation No. 27 concerned the evaluation of the methodology and the results of current experimentation with coverage of second opinions prior to elective surgery. The Board and the House concurred that third-party payors, working with providers, should undertake conscientious evaluation of this option. However, they also adopted the following policy statement:

(continued on page 520)

RESOLVED, That the House of Delegates of the American Medical Association adopt a policy statement on mandatory consultation as follows:

"Recognizing that the advisability of surgery or other specific therapy can be a matter of opinion, the House of Delegates of the American Medical Association (1) reaffirms the right of a patient or a physician to seek consultation freely with any consultant of his/her choice: (2) opposes the concept of mandatory consultation when required by a third-party payor; (3) supports the concept that when consultation is required by a third-party payor, the consultation should be at no cost to the patient; (4) opposes the concept of closed panels of consultants; and (5) supports the concept that if consultation is required by a third-party payor, the patient should be allowed to choose a physician of his/her choice."

★ The House rejected the concept of Recommendation No. 28, Inappropriate Medical Care. This recommendation called on the medical profession and others, working together, to examine those factors associated with medical practice that lead to utilization of inappropriate care, and to assume responsibility for informing providers and consumers of their existence and impact. The House referred the matter to the Board of Trustees for study and a report at the 1978 Interim Meeting.

National PSRO Guidelines

† The Ohio resolution entitled "Establishment of National PSRO Council Guidelines" called for the AMA to oppose vigorously the establishment of national PSRO criteria without a provision for local amendment or modification. This resolution was amended by the additional statement: "and the criteria be used for screening purposes only subject to peer review." The resolution was adopted as amended.

The Council on Medical Service Report G also dealt with professional standards review organizations (PSROs). This report notes that a recent U.S. District of Columbia Court ruling states that a PSRO is an agent of the government for purposes of information disclosure under the Freedom of Information Act. The result of this ruling is that previously confidential profiles on the performance of individual physicians and hospitals maintained by PSROs now are subject to public scrutiny. The American Association of Professional Standards Review Organizations and the Department of Health, Education, and Welfare intend to appeal this ruling. An alternative would be legislative action to exempt PSROs from disclosure requirements of that Act. The ruling was the result of a lawsuit filed by the Ralph Nader-affiliated Health Research Group.

In addition, Report F of the Council on Medical Service gave a detailed review of the health planning situation and the need for increasing physician participation in this process. OSMA members who serve on health systems agencies (HSAs) should obtain a copy of this report from the OSMA Headquarters office and submit it to the local HSA board.



LEFT TO RIGHT: John H. Budd, M.D., presents the Sheen Award to Karl A. Menninger, M.D., as Russell Yetter, Trust Officer, Guarantee Bank and Trust Co. of Atlantic City, New Jersey, observes. (Photograph by Joe Fletcher, AMA Staff.)

Reference Committee B Legislation

Certificate of Need

This Reference Committee considered six resolutions which pertained to certificate of need. The Resolution Committee recommended and the House approved the adoption of two of these. Since the proposed amendment to the present Health Planning and Resources Development Act would extend certificate of need to physicians' offices, the first resolution reaffirmed the AMA's opposition to the extension of certificate of need at all levels of government to private physicians' offices. The second stated (1) "that the AMA continue its opposition to the objectionable parts of HR 10460 and S 2410 (the proposed amendments to the Health Planning Act)," (2) that the AMA be commended for its efforts to remove certificate of need and the decertification sections from this legislation, and (3) that the AMA, with the assistance of state and county medical societies, inform congressmen of the AMA's determined opposition to these proposed intrusions by the federal government into the private practice of medicine.

Recommendation No. 18 supports the concept of planning. It states that there should be continued monitoring of existing certificate-of-need legislation in relation to cost benefits and effectiveness and establishment of equitable techniques for its administration. It recommends that certificate-of-need coverage be restricted to large capital expenditures of $150,000 or more. The Board of Trustees and the House adopted the following response to this recommendation:

The concept of voluntary planning is supported. There should be continued monitoring of existing planning legislation as to cost, benefits, effectiveness, and establishment of equitable

(continued on page 522)

picolife

Life Insurance, With A Difference

Endowment At 65

Matured endowments paid by U.S. life companies last year exceeded one billion dollars.

This form of life insurance is popular because it combines life protection with the assurance of funds for retirement or other purpose at the plan's maturity date.



PICO's endowment plan provides for payments at age 65. Of course, until the maturity date, the face value of the plan applies as life insurance protection.

The primary difference between our endowment plan and others that may be offered to you is that it was developed and is being marketed by an insurance organization formed specifically to serve physicians. We think you'll find the features of our plan particularly appropriate to your situation. Our rates are very competitive and you can count on complete professional services.

A PICO Life representative will provide you with personalized information about our endowment plan. It is a part of a life insurance program that includes permanent life insurance protection plans, retirement plans and annuities. Life insurance, with a difference.

PICO Life Insurance Company
6100 Channingway Boulevard
Columbus, Ohio 43227
Telephone 614/864-0280

picolife

A Subsidiary of Physicians Insurance Company of Ohio



LEFT TO RIGHT: Hart F. Page, C.A.E., OSMA Executive Director and President-Elect of the American Association of Medical Society Executives; Herbert E. Gillen, OSMA Associate Executive Director; and Jerry L. Hammon, M.D., West Milton. (Photograph by L.A.P.)

techniques for administration of federal requirements. The AMA opposes the imposition of the public-utility type of regulation of the medical profession, both institutional providers and the private physicians. Certificate of need is a nonproven concept at this time and requires continued evaluation.

★ In addition, Recommendation No. 19 of the Cost Commission calls for the expansion of certificate of need to provider settings outside the hospital, including private physicians' offices. This concept was rejected by the House of Delegates as being inappropriate and unnecessary. The following policy statement of the AMA was reaffirmed:

> The AMA is prepared to join with the State medical society, at the request of the Society, that commences an appropriate legal action challenging a state certificate-of-need law that includes physicians offices in that state.

Federal Regulations

In the area of federal regulations and cost control, a substitute resolution, submitted by the Illinois Delegation, was adopted which states:

> RESOLVED, That the AMA request the federal government to refrain from implementing further regulations and health care systems without supportive evidence of positive impact on quality of care and cost containment, or positive impact upon the quality of care alone."

★ Recommendation No. 17 of the Cost Commission states that the costs of regulations of all kinds, both governmental and voluntary, have significant impact on the total cost of health care. Government as well as providers of care should give attention to simplification of the regulatory process and to consolidating and reducing the number of inspections, audit surveys, reports, and the like. The Board and the House concurred with the additional comment that the recommendation be applied to all levels of government.

National Health Insurance

Several resolutions were presented to the House dealing with the nature of national health insurance, the AMA's current national health bill, and future legislation to be considered by the 1979 Congress. Individuals who testified at the Reference Committee hearing, including representatives of the Ohio Delegation, emphasized the importance of discussing the key points of any proposed AMA-sponsored health bill prior to its introduction. As a result of lengthy discussions, the Council on Legislation and the Board of Trustees will submit a report to the 1978 Interim Meeting so that the House can finalize this issue before a bill is introduced into the next Congressional hopper. The Council on Legislation will solicit the views and recommendations of state and specialty medical societies prior to developing recommendations to be submitted to this session of the House of Delegates.

Allied Health Professionals

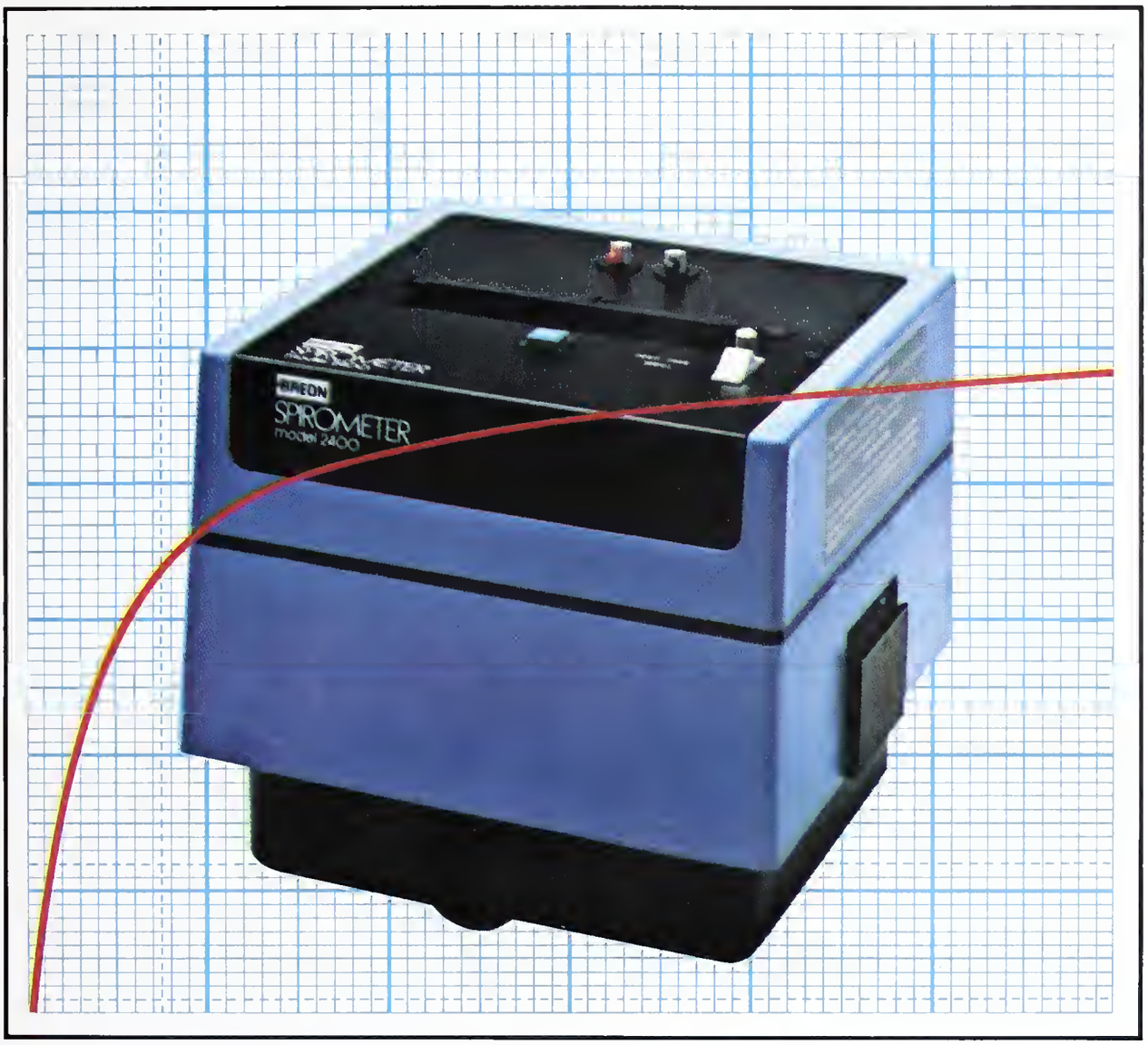
★ Recommendation No. 40 of the Cost Commission states that legislative restrictions should be modified regarding the use of allied health professionals under the supervision and direction of a licensed physician who is responsible for the performance of that assistant. It also indicates that there is a wide discrepancy between the number of tasks physicians believe could be delegated to support personnel and the number of tasks physicians actually would delegate. Considerable testimony and strong reservations were expressed concerning the endorsement of this recommendation without further study and evaluation. The Reference Committee felt that further study of this matter is warranted, and the House concurred that this important issue be returned to the Board of Trustees for development of a stronger physicians' statement for consideration at the 1978 Interim Meeting.

(continued on page 525)



Stewart B. Dunsker, M.D., Cincinnati. (Photograph by L.A.P.)

SPIROMETRY MADE SIMPLE



Introducing the **BREON** SPIROMETER

MODEL 2400

- Positive Displacement Direct Reading Spirometer
- Simple to Use
- Easy to Interpret

For more information send in this postage-paid card.

First Class
Permit No.
59720
New York, N.Y.
10016

BUSINESS REPLY MAIL
No postage necessary if mailed in the United States

Postage will be paid by:

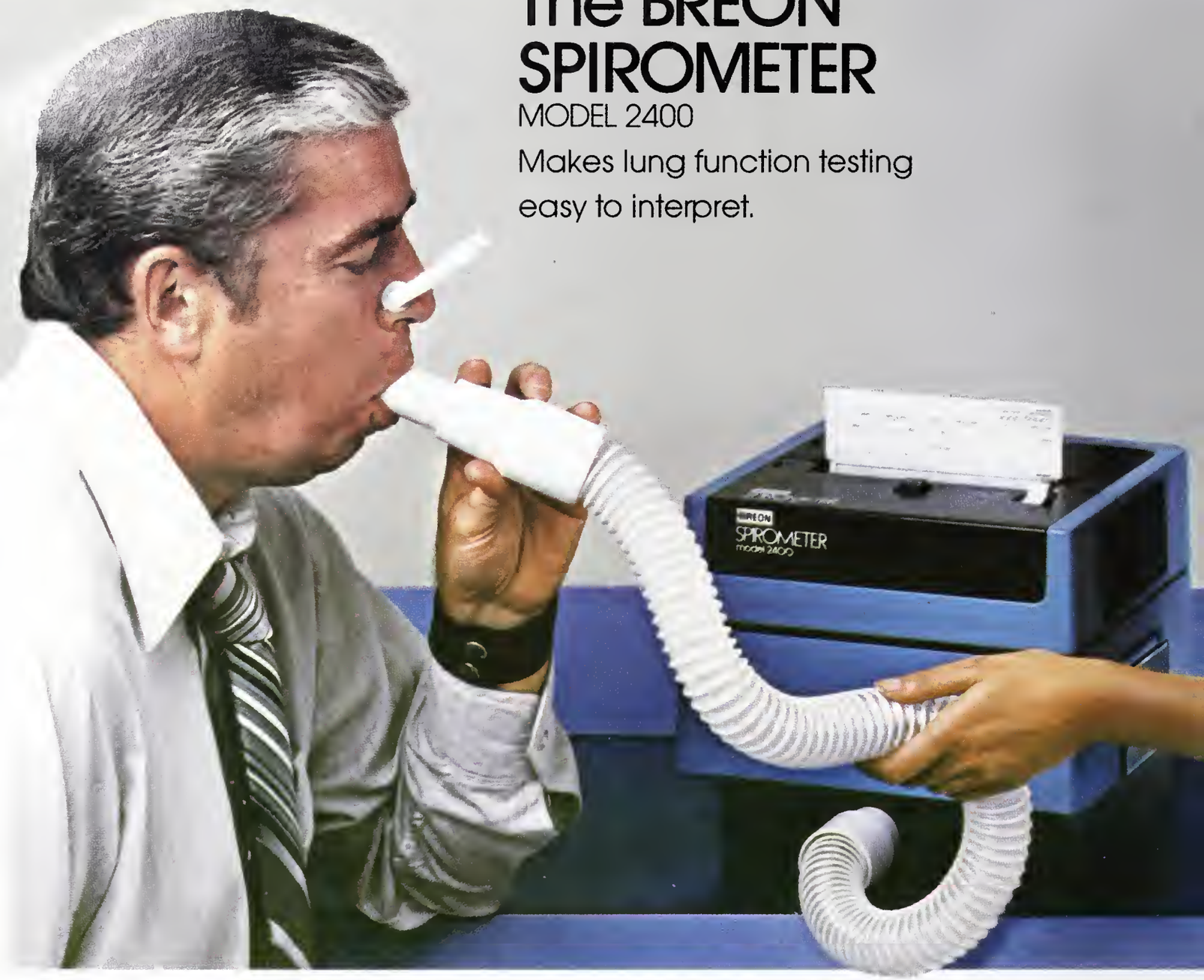
Breon Laboratories Inc.
90 Park Avenue
New York, N.Y. 10016

Attn: M. Trepicchio

The BREON SPIROMETER

MODEL 2400

Makes lung function testing easy to interpret.



- Provides a permanent record of results
- A single test provides most common and useful readings.
- ±1% accuracy at full scale
- Weighs less than 10 pounds
- Economical to use

I'd like to know more about office spirometry and the **Breon SPIROMETER Model 2400.**

☐ Please send me more literature.

☐ Please have your representative call.

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____

For more information send in this postage-paid card.

BREON

Breon Laboratories Inc.
90 Park Avenue
New York, N.Y. 10016

Reference Committee C
Medical Education

Physician Supply and Location

★ Recommendation No. 21 of the Cost Commission encourages the development of guidelines other than on a national basis to determine what health personnel facilities are needed in various geographic areas to meet expected demand for health services. Recommendation No. 33, Physician Supply, states that there should be no new efforts to increase the number of medical school graduates until such time as necessity for change clearly is evident. The Board of Trustees recommended and the House approved referral of these matters for expanded evaluation and reports at the 1978 Interim Meeting. In addition, the existing policy of the AMA was reaffirmed:

That the AMA continue to use its influence to encourage all reasonable expansion of student enrollments in existing medical schools and that the AMA support the development of new medical schools in locations where there is demonstrated local initiative and ample commitment of financial support.

★ Recommendation No. 34 calls for more effort to improve the professional attractiveness of service in shortage areas. Use of preceptorships and other rural or intercity training programs would be instrumental in acquainting physicians with medical practice in shortage areas. However, the potential impact of any program would be limited without an effort to provide an environment and resources that would increase the number of physicians who remain in an underserved community after such training. The Board of Trustees and the House endorsed this recommendation.

Foreign Medical Graduates

Illinois addressed the problems that foreign medical graduates are having under the Health Professions Educational Assistance Act of 1976 (PL 94-484) as it pertains to the appropriate examination to make them eligible for immigrant visas. The law also restricts post-graduate training for immigrant physicians to two years with a possible one-year extension, whereas most training programs in this country are four or five years in length. The House passed the following resolution:

RESOLVED, That the AMA strongly urge the Secretary of Health, Education, and Welfare to recognize examinations given by the Education Commission for Foreign Medical Graduates (ECFMG) and FLEX and/or state medical licensure exams, as equivalent to the Visa Qualifying Examination of the National Board of Medical Examiners for purposes limited to provisions of PL 94-484 for those alien FMGs who have approved or had applied for third-preference petitions and possess a valid license to practice medicine in a licensing jurisdiction of the U.S. prior to January 10, 1977.



LEFT TO RIGHT: John E. Albers, M.D., Cincinnati; John R. Beljan, M.D., Dayton, newly elected member of the AMA Council on Scientific Affairs; and H. William Porterfield, M.D., Columbus. (Photograph by L.A.P.)

Reference Committee D
Hospital and Medical Facilities

Cost

★ Cost Commission Recommendation No. 12, Perspective Rate Setting for Hospitals, calls for the hospital industry to develop payment schedules based on prospectively determined rates and other payment systems which also create incentives for facilities to be more cost conscious. The House adopted the following response to this recommendation:

The AMA endorses in principle Recommendation 12. Moreover, the AMA believes that payment for institutions on the basis of prospectively determined rates, and other payment systems which also create incentives for facilities to be more cost conscious, should be explored. However, such systems should be implemented only if they prove to be effective.

★ In Recommendation No. 10, the hospital industry, with participation from outside industry and full involvement of medical staffs, is asked to implement a structured voluntary cost constraint program, based on periodic review and public notice of all hospital expenditures exceeding a predetermined acceptable limit. The Board of Trustees and the House endorsed Recommendation No. 10 and its implementation to the extent feasible under existing law.

★ Recommendation No. 13 calls for programs to provide incentives to hospitals to limit bed capacity according to the needs of the population who serve the hospitals. The Board of Trustees and the House of Delegates endorsed this recommendation but also referred it to the Board of Trustees with authorization to work with appropriate hospital organizations to develop such voluntary programs.

★ In addition, Recommendation No. 39 states that physicians should be encouraged to enter or acknowledge the cost or charge for hospital-based services. The House of Delegates approved the following response:

RESOLVED, That physicians should be encouraged to be knowledgeable about and to consider the cost, charge, and reimbursement mechanisms for hospital service.

(continued on page 526)

Several resolutions addressed the issue of cost containment activities and the matter of government-operated hospitals not using the same criteria for voluntary cost containment as exercised in the private sector. The adopted resolution provides that any cost containment recommendation or activities adopted by the AMA be applied equally to state and federal hospital programs.

Hospital Boards of Trustees

† The issue of lay boards of trustees mandating policy to the medical staffs of hospitals was addressed. The resolution submitted by Ohio referred to situations where hospital boards of trustees unilaterally are mandating policies which, in effect, alter previously adopted medical staff bylaws. A substitute to the Ohio resolution was adopted as follows:

RESOLVED, That the AMA support the right of all medical staffs to conduct the practice of medicine in all facilities according to the rules and regulations governing the staffs as set forth in the bylaws, rules, and regulations drawn up and adopted by the medical staffs and approved by the governing bodies; and BE IT FURTHER

RESOLVED, That the AMA oppose any unilateral action of hospital boards of trustees that alters or bypasses previously adopted and approved medical staff bylaws, rules, or regulations.

Strikes

Report H of the Board of Trustees responds to a resolution submitted one year ago regarding strikes in the health care system. That resolution called on the AMA to prepare policies and strategies to deal with strikes, lock-outs, job actions, and other work stoppages that affect the quality and availability of medical care. The Board of Trustees feels that it is not feasible to establish definitive policies and occupational groups in the health care system, but it has established the Department of Negotiations which is aiding and training society officials and staff in alternative means of resolving disputes. Training programs have been instituted; and at the same time, the Office of General Council keeps abreast of pertinent new legislation and court decisions. Requests for assistance in disputes involving physicians may be referred through county or state medical societies to the Department of Negotiations or the Office of General Counsel. The AMA is well prepared to respond promptly.



LEFT TO RIGHT: OSMA President-Elect Thomas W. Morgan, M.D., Gallipolis; and OSMA Secretary-Treasurer Robert G. Thomas, M.D., Elyria. (Photograph by L.A.P.)



LEFT TO RIGHT: Mrs. John H. Budd and Mrs. Tom E. Nesbitt. (Photograph by Joe Fletcher, AMA Staff.)

Reference Committee E
Scientific-Public Health

Policing the Ranks

★ Recommendation No. 29 of the Cost Commission suggests that the medical profession should encourage increased efforts to develop effective means for dealing with those providers of medical services who are found to be abusing or defrauding the health care financing or delivery system. This recommendation was endorsed by the House with the following addition:

. . . provided that existing policies for the provision of legal immunity for physicians reporting instances of possible fraud be reaffirmed, and that prosecution of physicians accused of fraud is not appropriate in the absence of a finding of guilt.

Patient Education

★ Recommendations No. 46, 47, and 48 of the Commission dealt with health and patient education, private sector involvement in education, and healthful life styles. These along with four resolutions on these issues were consolidated into the following statement:

RESOLVED, That the AMA continue to augment the leadership role of the medical profession in developing and promoting health education materials and programs to moti-

vate Americans of all ages to maintain more healthful life styles and to assume more responsibility for the maintenance of personal health; and BE IT

RESOLVED, That the AMA continue to cooperate in the coordination of efforts in the public and private sectors to make health education more effective; and BE IT FURTHER

RESOLVED, That the AMA explore ways to assure more effective dissemination and sharing of effective efforts to develop and promote health education information and materials.

Sterlization

Federal regulations on sterilization and opposition to the waiting period in sterilization guidelines was resolved by a substitute resolution of the Reference Committee. The House adopted the resolution which stated:

RESOLVED, That the AMA reaffirm its position that the Secretary of Health, Education, and Welfare be requested to amend regulations entitled "Special Requirements Applicable to Sterilization Procedures" to permit more expeditious, economical, and flexible management of voluntary sterilization procedures.

The issue of opposition to restrictions in public funding of abortions was introduced through a resolution that subsequently was substituted by Massachusetts:

RESOLVED, That the American Medical Association oppose legislative proposals that utilize federal or state health care funding mechanisms to deny established and accepted medical care to any segment of the population.

Reference Committee F
Board of Trustees

The Board of Trustees recommended that the report of the National Commission of Medical Care be filed. The House also adopted the following statement: "AMA Delegates believe that the greatest hope for cost containment in the provision of health care lies in strengthening price consciousness in the health care marketplace." The Board of Trustees were commended by the House of Delegates for their foresight in creating the Cost Commission. The House concurred that the concepts generated from this Commission will be very helpful in addressing the various issues in the current complexities of health care problems. Certainly, there was not unanimous support of the Commission report or of its concept, but the overall effectiveness of this objective report is very worthwhile for the public and the profession.



LEFT TO RIGHT: Thomas E. Fox, M.D., Mason; and Edward E. Grable, M.D., Canton. (Photograph by L.A.P.)



LEFT TO RIGHT: George N. Bates, M.D., Toledo; and Richard L. Fulton, M.D., Columbus. (Photograph by L.A.P.)

Dues

The AMA dues will continue at the present rate of $250 in view of the very excellent financial report offered by the Board of Trustees and the Executive Vice President. The auditors' report confirmed the fact that the financial status of the organization is now stable, and that we are regaining the reserve status that is desperately needed for sound financial operations. The Board of Trustees and their Finance Committees were commended by the House for their activities in this regard.

The issue of reducing dues for new members as an inducement for membership in the AMA was discussed thoroughly, and the House adopted a report from the Board recommending a 50% reduction in dues for one year for physicians joining the AMA within the first five years of entering practice. In conjunction, state medical societies will be requested to reduce dues for new members in their first year of practice and take advantage of this opportunity for membership development.

The Resident Physician Section submitted a resolution requesting that every new member of the AMA receive a copy of the AMA *Principles of Medical Ethics* when he/she is accepted into membership. This was adopted by the House.

(continued on page 528)

Department of HEW Income Disclosure

The problem of the Department of Health, Education, and Welfare releasing physicians' names and fees was presented by the Florida Delegation. An amended resolution was adopted as follows:

RESOLVED, That the AMA continue to pursue appropriate legal recourse to prevent the Department of Health, Education, and Welfare from releasing the names of individual physicians and their income information contained in Medicare records.

†The Ohio resolution on cost containment asked the AMA to continue and to intensify efforts to promote voluntary cost containment without compromising quality of care, to urge a similar commitment to cost containment in government health care facilities, and to urge limiting government cost control programs to costs directly related to meeting government regulations. Testimony resulted in adoption of the Ohio resolution with a substitute for the third "resolved," so that the resolution states:

RESOLVED, That the AMA continue and intensify its efforts through its established committees and through its association with others to promote effective voluntary health care cost containment in those areas under the control of these groups while not compromising quality of care; and BE IT FURTHER

RESOLVED, That the AMA urge similar commitment to cost containment by government within all health care facilities operated by governmental agencies; and BE IT FURTHER

RESOLVED, That the AMA urge all departments of government to acknowledge the impact that governmental regulatory controls have on health care costs; and BE IT FURTHER

RESOLVED, That this resolution be presented to the appropriate federal agencies.



LEFT TO RIGHT: Theodore J. Castele, M.D., Cleveland; and John E. Albers, M.D., Cincinnati. (Photograph by L.A.P.)



LEFT TO RIGHT: Jerry L. Hammon, M.D., West Milton; and Jack Schreiber, M.D., Canfield. (Photograph by L.A.P.)

Legal Assistance to Members

†Another Ohio resolution sought the appointment of an Ad Hoc Legal Assistance Committee to investigate the feasibility of providing legal aid to members on issues of common interest and to report these findings to the Board of Trustees. The entire issue has been referred to the Board of Trustees for consideration and report to the House at the 1978 Interim Meeting.

The untimely comment by President Carter on the medical profession was addressed in a resolution from Florida. It was passed and states:

RESOLVED, That the AMA repudiate the unjustified attack of the President of the United States on the AMA and the physicians, patient care, and advancement of medical science which it represents.

Reference Committee H
Miscellaneous

★ Recommendation No. 30 of the Cost Commission calls for providers and courts to use guidelines of appropriate care for guidance as to what constitutes acceptable levels of performance on the part of physicians and other providers. This section has been referred to the Board of Trustees for continued and expanded study. The second part of this recommendation stated that the medical and legal professions, working together with third-party payors, should examine the feasibility and desirability of having the resolution of professional liability claims placed outside the traditional court room-jury setting. This was endorsed by the Trustees and the House.

Summary

This report only presents highlights of the 1978 American Medical Association Annual Meeting. Further information on any of these or additional items of business may be obtained by contacting any delegate or alternate delegate or by writing or calling the OSMA Headquarters Office, 600 South High Street, Columbus 43215, phone: 614/228-6971.

Saint Anthony Hospital

presents

"Monitoring the Critically Ill Patient: Medical vs. Surgical Management of Coronary Artery Disease."

on Sunday, October 29, 1978 featuring

Louis R.M. Del Guercio, M.D. — Professor and Chairman, Department of Surgery, Medical School of New York

Andrew G. Wallace, M.D. — Professor of Medicine and Chief, Division of Cardiology, Duke University

Max. H. Weil, M.D. — Professor and Director, Center for the Critically Ill, University of Southern California School of Medicine.

All sessions will be in the Franciscan Center, Saint Anthony Square, 1441 Clifton Avenue, Columbus, Ohio

C.M.E.s — Category I — 7 hours
$50 registration fee includes lunch and all materials.

Mail to: Mrs. Dale Nelson, SAINT ANTHONY HOSPITAL, 1450 Hawthorne Avenue, Columbus, Ohio 43203

CHECKS MUST ACCOMPANY RESERVATIONS

Enclosed is $_____ to cover _____ reservations.

Name_____

Address_____

City_____ State_____ Zip_____

contains no aspirin

tablets

Darvocet-N® 100 Ⓒ IV

100 mg. Darvon-N® (propoxyphene napsylate)
650 mg. acetaminophen



Lilly

Additional information available to the profession on request from Eli Lilly and Company Indianapolis, Indiana 46206

700565

Eli Lilly and Company, Inc.
Carolina, Puerto Rico 00630

Address of the President, American Medical Association

John H. Budd, M.D., Cleveland,
President, American Medical Association

In the past couple of years, I've had the pleasure of steady travel to our state and county societies, and always returned home with a great deal more than my luggage.

I returned with heart-warming fresh insights into the men and women who constitute our profession. I constantly was struck by their dedication— not only the **intensity** of it but also the **variety.**

Despite a work week that nationally averages 52 hours, and despite other professional obligations, many scrape up the time to be community leaders. I met a dozen or so who held such elective positions as mayor, county commissioner, school-board member. These physicians demonstrate that public service is natural to the private service we give our patients, and can walk hand in hand with it.

The further thought occurs to me that membership in the American Medical Association is in and of itself a public service.

Can you think of any current or recent AMA effort in the halls of legislation, or in the courts of law, that has not been directed at the health and well-being of the American people— rather than simply at what are sometimes said to be our own ends?

I can think of only one: revision of the Keogh Plan. And I don't think anyone would begrudge us an agreeable retirement.

Our efforts have been loyal to the goal laid down in our Association's constitution— the goal of promoting "the science and art of medicine and betterment of public health." Often this means we must protect medicine in all of its delicate identity and interrelationships— against heavy-handedness on the part of government.

One discrepancy is that government tends to see health services through field glasses, whereas the quality and sufficiency of care, being individualized, must also be seen at close range.

For us in medicine, the patients we serve are not a mass or a throng, but individuals multiplied. Hence, our view is a compassionate one, and we have served them with compassion and understanding.

Let me roll-call some of the ways in which the AMA has done so.

★ We have fought for changes in that great time bomb, the Health Planning Act. The AMA has always endorsed voluntary health planning, but this act is becoming **more planning than health.** Convinced that the focus of planning should be local, we have pushed for amendments that would limit HEW's power in this sphere and ensure that HEW's planning guidelines are to be advisory only.

The revised guidelines now in effect are just about as self-important as the original set, and just about as contemptuous of the role to be played by local Health Systems Agencies. The result could be arbitrary allocation and even gerrymandering of heath resources. A number of communities— including their HSA officials— are afraid that necessary facilities will be closed or impaired.

★ Another AMA effort on Capitol Hill is in behalf of the proposed Sunset Act which would require regulatory agencies to justify their right to eternity and make them more accountable to Congress.

★ Also on the Hill, we supported the principle of the legislation aimed at Medicare/Medicaid fraud and abuse. What's more, we improved the act by helping eliminate the unwieldy, costly "program review teams," which would have duplicated PSRO.

★ In many of our battles, our very status as a profession is at stake. Consider the forays by the Federal Trade Commission against some of the very keystones of our aggregate professionalism. The FTC has been trying to dislodge the Liaison Committee on Medical Education as accrediting body for medical schools. Seeing the American Medical Association in every medical woodpile, the FTC contends that it dominates— or domineers — the Liaison Committee.

The agency has offered no evidence that the committee lacks autonomy or embodies a conflict of interest. While the AMA and the Association of American Medical Colleges have helped guide the committee in policy development, there is nothing in the policy that would limit the number of medical schools and physicians. Nor do committee members consult with those two associations when evaluating a school.

Perhaps the most clear-cut rebuttal of the FTC's contention is the following statistics:

Accredited U. S. medical schools have increased from 88 in 1966 to 123 today. Entering enrollment in the past decade has about doubled. And since 1970, the number of physicians has risen four times as fast as the general population.

Those are the facts. And I think they help bear out our professional dedication.

Unfortunately, however, we live in a somewhat cynical era when being an authority in one's profession can carry less weight than being a government authority.

Obviously, the fountainhead of our professionalism, of our advancement as a science, is research. So I am somewhat dismayed by the bill, introduced in January by Senator Kennedy, that would create National Institutes of Health Care Research in HEW. They would be modeled after the National Institutes of Health but be separate from them and equal to them.

On the surface, the broad coordinative objectives of Senator Kennedy's bill, S 2466, may seem plausible. And certainly no one can quarrel with its stated intent of improving "the effectiveness, efficiency and quality of health care in the United States."

But I see potential dangers in this bill— dangers of retrenchment in care. On the basis of a patient's age or physical condition, or questions of technology, there could be retrenchment on such therapies as organ transplants, dialysis, artificial organs, heart bypass, and vein stripping.

You and I are so intent on the quality and sufficiency of care that anything alien to them is unconscionable. That quality, after all, took centuries to develop— a big proportion of it has come since World War II. And we have every reason to be proud of it and sworn to it.

Yet virtually all the federal programs and proposals I have mentioned, or could mention, are greatly concerned with cost: the Health Planning Act, for example, and possibly Senator Kennedy's S 2466. You and I want to look at medical science's loftiest levels while other people, most notably in Washington, are chiefly concerned with the economic bottom line. And that line is staggering. Last year the nation's health-care spending exceeded $160 billion— or four times the 1965 amount.

We of the American Medical Association realized that this relentless upsurge could not endure— or be endured. We saw the handwriting on the wall— and it was larger than our lives, and as big as government.

It would be easy, of course, to point to the government as the prime cause of inflation in health costs and to cite many other valid defenses. But we chose to take a bigger view and move with the bigness of that view.

Hence, as you all are thoroughly aware, we of the AMA created the National Commission on the Cost of Medical Care. That Commission is integral to the needs we have to face, in the times we have to face.

I am reminded of what President Abraham Lincoln said in his second annual message to Congress:

> The dogmas of the quiet past are inadequate to the stormy present. The occasion is piled high with difficulty and we must rise with the occasion. As our case is new, so we must think anew and act anew.



LEFT TO RIGHT: Three Generations of Budds— John H. Budd, M.D.; grandson John; and son, John H. Budd, Jr. (Photograph by Joe Fletcher, AMA Staff.)

And that is the spirit in which the diverse members of the Commission deliberated for a year and a half. The report, with its 48 recommendations, is new in its breadth of ideas— ideas geared toward equilibrium and fairness as well as effectiveness. What a contrast that is with the one-fell-swoop approach that the government often takes, as it would if it imposed a 9% ceiling on hospital cost increases.

Probably the chief focus of the Commission report is that it stresses the need to restore a great concept: the concept of market-place choice in health-care delivery.

What does that means? Well, by market place, we mean producers and consumers handling their transactions through insurers, private and public. It is not as flexible as in the days when consumers paid the producers directly. The patterns of coverage offered by today's middleman insurers are largely standardized in benefits and therefore in costs. The Cost Commission Report suggests ways in which those patterns can be stimulated to offer a latitude and freedom of choice, and enable producers and consumers to have direct impact on decisions made in their behalf.

For example, employees could choose among health-care plans in terms of premium price, whereas employer contributions to premiums would be the same for any plan. The employee selecting a plan less expensive than the employer contribution would either be reimbursed for the difference or receive additional benefits.

Another application of the general concept is the recommendation calling for market competition between various modes of health-care delivery.

While putting great emphasis on market place choice, the Commission recognized that there must be some

reliance on provider self-regulation, and on local regulation, if the overall tab is to be kept in line. But let me make it perfectly plain that no federal controls are recommended.

No one has pointed out the booby hatches of federal regulation more clearly than Stanford University economist Alain C. Enthoven, who writes:

> In recent years, the main line of government policy has been to attack the problems created by inappropriate incentives with various forms of regulation. The weight of evidence, based on experience in many other industries, as well as in health care, supports the view that such regulation is likely to raise costs and retard beneficial innovation.

Rejecting federal controls, the Commission report represents the "aggressive moderation" I described in an earlier address to this House. It calls upon voluntary initiative from health-care producer, consumer, and third parties.

Nor is the report a mere Madison Avenue bit of imagery. Already it is bearing solid results. It has helped stave off the arbitrary 9% cap proposed by the Administration.

Let me also cite a statistical example.

In harmony with one of the report's recommendations, the AMA, the American Hospital Association, and the Federation of American Hospitals have a voluntary cost-containment program. One goal of the Voluntary Effort— as it's called— is to cut the rate of increase in hospital spending by two percentage points a year. Well, initial results indicate that community hospitals have been cutting twice that much, in comparison with a year earlier.

But while sounding these optimistic notes, I must also sound a strong note of warning. I am fully aware that some features of the Commission report have raised eyebrows— and even a few tempers. Yet, to repeat those words of Lincoln, we can no longer live with "the dogmas of the quiet past." Today the great dogma is the cost of care.

Believe me, the choice is not between the status quo and change. The choice is necessarily between the right and the wrong kind of change. Which means the kind to which we can accommodate, or the kind to which we will be **forced** to accommodate. The Commission report is the light at the BEGINNING of the tunnel, and that tunnel can otherwise be very dark and never-ending.

Speaking as John H. Budd, I ask that this report be **substantially** adopted by this House.

I ask that it be seen as an inspired step that might stimulate other segments of society— even the federal government— to reef the sails on their ships of inflation and thus benefit the entire commonwealth.

I ask that the report be pondered with all of our sense of dedication and all of our common bond of professionalism.

And I ask that it be judged in these words from the *Book of Job:* "Thou shalt decree a thing, and it shall be established unto thee, and the light shall shine upon thy ways."

This year . . . the chances of your being seriously disabled are far greater than death.

THIS CHART SHOWS JUST HOW MUCH GREATER.

CHANCES OF DISABILITY VS. DEATH

If you are age	A disability of 90 days or longer is this much more likely to occur than death this year:
22	7½ TIMES GREATER
32	6½ TIMES GREATER
37	5½ TIMES GREATER
42	4 TIMES GREATER
47	3½ TIMES GREATER
52	2½ TIMES GREATER
62	2 TIMES GREATER

Source: The National Underwriter Company, 420 E. 4th St., Cincinnati, Ohio 45202

When disability occurs, will your protection be adequate?

To be sure you have an income when you're disabled, enroll in . . .
THE DISABILITY INCOME PROTECTION PLAN which your Ohio State Medical Association co-sponsors with many local medical societies. You may apply for benefits up to $500 weekly.

CONTACT:

TURNER AND SHEPARD INC.

Columbus, Ohio 43215	17 South High Street	Phone (614) 228-6115
Akron, Ohio 44313	3090 West Market Street	Phone (216) 434-5000
Cincinnati, Ohio 45241	4015 Executive Park Drive	Phone (513) 563-4220
Cleveland, Ohio 44134	1440 Snow Road	Phone (216) 741-4466
Toledo, Ohio 43606	3450 West Central Avenue	Phone (419) 535-0616

THE OHIO STATE Medical Association News

Update on Rocky Mountain Spotted Fever

—Courtesy Ohio Department of Health

There have been 17 reported cases of Rocky Mountain Spotted Fever (RMSF) this season (to July 12). Seven of these have laboratory support of four-fold titer rise using the complement fixation test; results of a number of others are pending. This compares to 28 cases in all of 1977, of which 17 were confirmed. The remaining cases were diagnosed on the basis of clinical findings, previous history of tick bite, and Weil-Felix test results.

Rocky Mountain Spotted Fever cases usually have onset dates between May 1 and August 31, the period of greatest tick activity. In a series of 87 laboratory confirmed cases, 89% had onset dates in this time interval. Individuals under 20 years of age accounted for 71% of these cases, while the age group from 6 to 10 years had the highest incidence (25%).

Although the nonspecific Weil-Felix reaction with OX-2, OX-19, and OX-K is widely employed, a positive test is at best only presumptive evidence of rickettsial infection. The complement fixation (CF) test is the most reliable procedure currently available, but requires that acute and convalescent sera be drawn at least 10 to 14 days apart to demonstrate a significant rise in antibody titer. In cases where intensive antibiotic therapy is initiated early in the course of illness, development of antibodies which normally occur in convalescent patients may be delayed. Under these circumstances, a late convalescent specimen is required. Physicians seeing patients with suspected RMSF are urged to submit acute and convalescent sera to the State Health Department Laboratory for CF testing.

The Vector-borne Disease Unit (Communicable Disease Division, Ohio Department of Health) currently is conducting a tick vector testing program in which live ticks may be submitted for examination to determine the presence of spotted fever group rickettsiae. It is hoped that this program will provide information on prevalence and distribution of ticks infected with *R. rickettsii* in Ohio.

To submit ticks for examination, place live ticks in a small, clean, tightly capped bottle or vial containing a strip of paper towel moistened with one drop of water. Do not perforate the cap— sufficient air will be available to keep the tick alive during shipment. Place the bottle in a standard mailing tube along with the following information: date collected; county, specific locality; person or animal on whom tick was found; collector; and mail it to: Vector-borne Disease Unit, Ohio Department of Health, P.O. Box 2568, Columbus, Ohio 43216.

Only through reporting and accurate diagnosis of cases, coupled with field and laboratory investigations of ticks, can sources of infection be located and appropriate control recommendations be made. By reducing tick populations, foci of infection can be eliminated and the incidence of human cases can be reduced.

AMA Polls Physicians on Health and Exercise Habits

A recent AMA poll of physicians' health and exercise habits gives insight into America's physician population. According to the poll, the jokes about doctors on the golf course will have to be laid aside because only 10.7% of those responding play golf. The most popular sport among those who exercise regularly is jogging, followed by tennis and swimming.

Stress, overwork, and exposure to infectious disease are the three health hazards of medical practice mentioned most often by those polled. Whereas ten years ago 30% of physicians smoked, only 18.2% do so today. Also, they hold down their weight. Just one fourth of physicians admit to being more than ten pounds overweight.

Finally, physicians follow the adage: "The physician who treats himself has a fool for a patient." Four out of five say they go to a colleague when in need of medical attention.

Medical Board Activity

The following is a list of activities and actions undertaken from May 1, 1978 to May 31, 1978 by the Ohio State Medical Board.

LICENSURE ACTIVITY

American and Canadian Graduates		
Licensed by Endorsement	M.D.	92
	D.O.	9
Licensed by Examination	M.D.	0
	D.O.	0
Foreign Medical School Graduates		
Licensed by Endorsement		32
Licensed by Examination		0
Sept. 1972 FLEX Board Policy Licenses		2
Endorsements to Other States	M.D.	67
	D.O.	4

ENFORCEMENT ACTIVITY

Formal Citations Issued	7
Board Office Visits with Individuals in Alleged Violation of the Medical Practice Act	4
Voluntary Surrenders of Medical Certificates	1
Arrests for Alleged Illegal Practice of Medicine	1
Formal Hearings on Alleged Violations of the Medical Practice Act	4

Booklet on Hiring Available

The American Professional Practice Association has issued a new booklet entitled "Hiring a Junior: Employment Negotiations From the Senior's Perspective," which they are making available free on request to practicing physicians and dentists. Written by two New York attorneys, the booklet covers a wide range of topics including the reasons for hiring a junior, how to find a compatible associate, negotiating the compensation package, and determining when the junior should become "equal." In addition, the authors discuss at length two controversial areas: managerial control and the restrictive covenant. To obtain the booklet, write American Professional Practice Association, 292 Madison Ave., New York, New York 10017.

Cincinnati Hospital Administrator on National Health Care Committee

Sister Grace M. Hiltz, President of Good Samaritan Hospital, Cincinnati, is a trustee of the newly formed National Committee for Qualty Health Care. Members of this committee represent hospital administrators and other nonprofit health care officials, architects, building contractors, financing executives, and other suppliers to the health care industry. It was conceived "in the belief that the cost of health care in the United States is rising too rapidly and must be restrained; that a high level of quality must be maintained in the delivery of health care service; and that these two goals are compatible," said a spokesman for the group, Thomas W. Reed, President of Blyth Eastman Dillon Health Care Funding, Inc.

A ten-point plan offered by the committee proposes to:

1. Limit construction of new hospital beds except in medically underserved areas;
2. Provide incentives for closing unneeded or seriously underutilized facilities;
3. Maintain the quality of the physical plant of hospitals which provide needed and appropriate services;
4. Strengthen the local planning process by equalizing provider and planner access to professional consultants;
5. Review proposals for capital expenditures in light of full life-cycle costs and potential impact on the local health systems plan;
6. Encourage cost-effective sharing of hospital services;
7. Promote reasonable access for all patients to state-of-the-art medical technology;
8. Adopt incentive-oriented payment processes in lieu of current retrospective reimbursement;
9. Develop a national data base for capital expenditure policy through survey of local needs; and
10. Demand full utilization of current cost containment authority during consideration of new strategies.

(News continued on page 536)

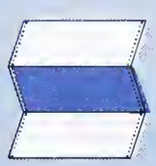
Fine Tailors

Medical Data Systems® are tailored to the individual needs of groups, clinics and labs. Begin with the basic service bureau concept and phase-in your own in-house operation. In the interim, S-Tek takes full responsibility for installation, education and training and procedures.

S-Tek Computers Services — The Data Processing Tailors

MEDICAL DATA SYSTEMS®

Call or write our Sales Department for more information.



S-Tek
COMPUTER SERVICES, INC.
P.O. BOX 328 TERRE HAUTE, IN 47808 812-232-1385
Medical Data Systems, a registered trademark of S-Tek Computer Services Inc.

News *(continued)*

Fee Increase Ceiling Announced by Wisconsin Blue Shield Plan

A 5% ceiling on physician fee increases for the next 12 months was announced by Wisconsin's largest Blue Shield Plan on June 1. The Plan said the fee increase ceiling is unprecedented in the health insurance industry and it is being undertaken with the cooperation of physicians throughout the state. Plan spokesmen expressed the hope that this type of measure would spread to other health-care areas such as hospitals, but the Wisconsin Hospital Association (WHA) took exception to the assertion, stating that it is inappropriate for Blue Shield to make decisions for the hospital field. The WHA also commented that the state's rate review program has effectively controlled hospital cost increases.

Physician Shortage Criteria

Under new criteria proposed by the Department of Health, Education, and Welfare's Bureau of Health Manpower, the number of Americans living in areas officially designated as having a physician shortage could increase by 56% to a total of 25 million. Under current rules, a shortage level is reached when there are 4,000 or more persons per primary care physician. The new proposal would lower this level to 3,500. Of the estimated 25 million people who would be in shortage areas under the new criteria, 15 million live in inner cities.

Medical School Sponsors Swim Meet for Mentally Retarded

Recently, Wright State University School of Medicine sponsored a swimming meet for mentally handicapped youngsters. According to David Hedden, a second-year medical student, "Our goal was to learn about the behavior of mentally retarded adolescents and young adults in a nonclinical setting." Also, parents were made aware of their children's potential for physical and social achievement. Thirty-five swimmers, ranging in age from 14 years to 25 years of age, and 40 medical students were involved in the experience. Mr. Hedden; Peter Imber, another second-year student; and Laurie Sabine, a first-year student, coordinated the event.

A Few Physicians Account for Successful Malpractice Claims

A small percentage of repeatedly negligent physicians accounts for a large percentage of successful medical malpractice claims, a Rand Corporation study reported June 8. Two researchers, a physician and a lawyer-economist, recommended that these physicians should pay higher malpractice insurance premiums to deter them from causing future malpractice injuries. The researchers presented evidence to disprove three widely held beliefs: that there are "too many" successful malpractice suits, that judgments are generally excessive, and that careful physicians are sued as often as negligent physicians.



Journal Advertisers

Breon Laboratories, Inc...523, 524
Brown Pharmaceutical Company, Inc.....502, 503, 514
Burroughs Wellcome Co.....494
Daneman Laboratories.....500
Immke Circle Leasing.....517
Eli Lilly and Company.....530
Harding Hospital.....517
Mead Johnson.....505, 506
Medical Protective Company..537
Menendian Carpets.....499
Ohio Medical Indemnity.....507
PBP Data Systems.....497
Pennwalt Prescription Products 486, 487
Physicians Insurance Company of Ohio, Inc.....490
PICO Life.....521
Practice Productivity.....512
Roche Laboratories, Div. of Hoffmann-LaRoche, Inc...Cover 2, Cover 3, Cover 4
Smith, Kline and French Labs 488, 489
St. Anthony Hospital.....529
Stanley H. Kaplan Educational Center.....536
S-Tek 535
Turner & Shepard, Inc.....533
United States Air Force.....508
United States Navy.....537
Upjohn Pharmaceutical Company.....510
Wendt-Bristol Company.....538
Windsor Hospital.....513

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

OHIO OFFICES:

CINCINNATI: Room 700, 3333 Vine Street, (513) 751-0657, L. A. Floherty

CLEVELAND: Suite 106, 23360 Chogrin Boulevord, Beachwood 44122, (216) 464-9950

A. C. Spath, Jr., R. A. Zimmermon

COLUMBUS: 1989 West 5th Ave., (614) 486-3939, J. E. Honsel

TOLEDO: 1011 Sandusky St., Suite H, P.O. Box 331, Perrysburg 43551, (419) 874-8080, R. E. Stallter

When was the last time your practice gave you a good night's sleep?

We're not talking about sleep that comes from sheer exhaustion.

We're talking about the kind of sleep that comes from knowing you practiced medicine today the way it was meant to be practiced. Of giving your patients the very best in medical care. With no compromises.

And a sleep that comes from knowing you won't be spending all of tomorrow morning filling out Medicare insurance forms, or attending to a myriad of other time-consuming, nonmedical duties.

But there is a practice that offers an alternative to the kind of medicine you're now practicing. A practice in the U.S. Navy.

The Navy physician.

As a Navy physician, we feel your time is too valuable to spend on administrative details. So they're kept to a minimum. Instead, a highly trained staff of professionals attends to the paperwork. The end result is that almost all your time can be spent practicing medicine.

A challenging practice.

You'll be given a practice that's as varied and challenging as any you'll find in a civilian setting. You'll be treating active duty personnel as well as their dependents and retired personnel.

Insurance.

A recent Act of Congress now makes it unnecessary for federally employed physicians to carry high cost insurance. As a practicing Navy physician, you will receive professional liability protection under the Federal Tort Claims Act.

Other benefits.

There are plenty of other great benefits that go with being a Navy physician. Good pay— $30,000 to start, more, depending on your experience. A family life with time for your family. Associating with other highly motivated physicians. Even 30 days' paid vacation a year.

But the best way to get all the facts is to mail the coupon, or call the Medical Recruiter, toll-free, 1-800-282-1288.

Be the doctor you want to be. In the Navy.

We create impressions...

First impressions for physicians' waiting rooms. As in the contemporary style shown here, we will design a waiting room that reflects your concern for quality, serenity and most importantly, your patients' total comfort. We will blend style and function in every other room of your office as well. Create an impression . . . call us. We're Medical Interiors, a division of the Wendt-Bristol Company.



AMERICAN SURGICAL TRADE ASSOCIATION A.S.T.A.

medical interiors
a division of THE WENDT-BRISTOL CO.
1107 dublin road p.o. box 144
columbus, ohio 43216

☐ please send a brochure explaining your design concepts.
☐ I'm interested in learning more about MEDICAL INTERIORS.

the wendt-bristol company

NAME

ADDRESS

CITY STATE ZIP

OSMJ-8/78

Classified Ads

Rates: $3 per line. Display classified: $5 per line. Minimum 3 lines per insertion. Ads measure 8 lines to the inch. Box number reply: Flat $5 charge in addition to line cost for up to and including three insertions. (Covers cost of mailing replies which are kept confidential.) Forms close the 10th day of the month preceding month of publication. Address all ads Attention: Classified Ad Department, ***The Journal.***

To assure prompt delivery, when replying to an advertisement over a ***Journal*** box number, address letters as follows: Box (insert number), c/o ***The Ohio State Medical Journal,*** 600 South High Street, Columbus, Ohio 43215.

PEDIATRICIAN AND OB-GYN: Board eligible or certified. Needed immediately for established multispecialty group in mid-Ohio community of 60,000+, next to 500-bed hospital. Liberal payment and benefits. Contact: J. Harold King, M.D., 295 Glessner Avenue, Mansfield, Ohio 44903, phone: 419/525-1111.

ANESTHESIOLOGIST: Needed for one of the leading university-affiliated hospitals in the Midwest. This is a challenging position for board-eligible or board-certified anesthesiologist with joint appointment through Case Western Reserve University School of Medicine. Ohio license required. New expansion program will represent 1000+ beds by the fall of this year. Excellent salary commensurate with experience and competitive benefits package. Please send resume to: Virgilio Glorioso, M.D., Interim Director, Department of Anesthesiology, Cleveland Metropolitan General Hospital, 3395 Scranton Rd., Cleveland, Ohio 44109.

An Equal Opportunity Employer

PHYSICIAN: With empathy toward college-age population to practice general medicine in 38-bed accredited hospital with large outpatient clinic. Salary negotiable, excellent fringe benefits. Contact I. W. Combs, M.D., Director, Purdue University Student Hospital, West Lafayette, Indiana 47907, phone: 317/749-2441.

Equal Access/Equal Opportunity Employer

PHYSICIAN RECRUITMENT: FAMILY OR GENERAL PRACTICE. Suburban Fort Myers, Florida, near Gulf and beaches. Two ambitious, Florida-licensed family or general practitioners. Independent practice with opportunity to engage in group. Minimum 2½ year commitment. Nearby hospital and wide range of specialty support. Office space immediately available. Excellent potential income. Financial options negotiable. Address resumes and inquiries to: Dr. P. Callahan, P.O. Box 1686, Largo, Florida 33540, phone 813/446-3245.

EMERGENCY MEDICINE: Ohio and western Pennsylvania. Occasional part-time or full-time work available. Excellent remuneration and flexible scheduling. Ohio or Pennsylvania license required. Contact: James Ginter, Regional Administrator, 931 Chatham Lane, Columbus, Ohio 43221, phone: 614/457-9761.

PEDIATRICIAN WANTED. For 47-man multispecialty group located in a prosperous central Ohio community. Present department includes four pediatricians providing 37,000 outpatient visits yearly. Attractive salary and unusual fringes, including retirement program; early partnership with minimum financial investment. Send C.V. or call collect to: Albert N. May, M.D. or Bruce Dyer, Executive Director, F. C. Smith Clinic, 1040 Delaware Avenue, Marion, Ohio 43302. Phone 614/387-0850.

MEDICAL OFFICE SPACE: Now under construction, Woodfox Center, corner of Mack & Winton Rds., Fairfield, Ohio. ¾ mile from new Mercy South Hospital. Call: Heckman & Gilliland 614/885-7300.

WANTED: Partner to race two-year-old thoroughbred this fall. Contact: Tom Reynolds at 614/837-1242.

(EDITOR'S NOTE: The Journal presents the above classified advertisement to its readers as an announcement and assumes no responsibility for the statements made.)

GENERAL MEDICAL OFFICES AVAILABLE FOR RENT: In Hartville, reportedly the fastest growing township in Ohio. New construction permitting individual furnishing. Physically attached to Cancer Center with diagnostic x-ray, laboratory, and pharmacy facilities. Contact George N. Swallon Agency, Canton, Ohio, 216/456-3495, or inquire of R. K. Loeffler, M.D., 650 South Prospect, Hartville, Ohio 44632.

(Classified Ads continued on page 540)

ANESTHESIOLOGIST WANTED: Full-time, incorporated practice. Suburban Cleveland location, 400-bed hospital; all types of anesthesia. We have five anesthesiologists and ten nurse anesthetists. Liberal fringe benefits, retirement plan, vacation, and time off after call. Send application and resume to: Box 833 c/o Ohio State Medical Journal.

OUTSTANDING OPPORTUNITIES: All specialties available immediately and for July 1979. Guaranteed incomes and many other benefits. Beautiful Ohio location. Send C.V. to: MRI, 104-70 Queens Blvd., Suite 301, Forest Hills, New York 11375 or call: Irv Swirsky, 24 hours 212/275-2121.

INTERNIST & SURGEON: Board eligible or certified. Needed immediately for established multispecialty group in mid-Ohio community of 60,000, next to 500-bed hospital. Liberal payment & benefits. Contact: J. Harold King, M.D., 295 Glessner Avenue, Mansfield, Ohio 44903, phone: 419/525-1111.

GENERAL PRACTICE PHYSICIAN WANTED: Office space available. North-central Ohio, population area 25,000. Ideal environment, excellent sports, recreational facilities, boating nearby. Near Lake Erie islands recreation area. Midway Cleveland-Toledo, 100 miles north Columbus. Modern 68-bed hospital. Good schools. Brochure on request. Write Box 831, c/o Ohio State Medical Journal.

OB/GYN: Well-established busy OB/GYN practice in Northeast Ohio for sale. Grossing over $150,000 per year. Fully equipped office and three examining rooms with the latest OB/GYN equipment. Will introduce you to patients. Price and terms negotiable. If interested, call 216/257-7227, Mentor, Ohio.

FOR LEASE: 2,000 sq. ft. medical office suite in Columbus, Ohio (northwest area), many "built-ins," off-street parking, full services, immediate occupancy. Phone for floor plan drawing 614/263-5469.

EMERGENCY PHYSICIANS: Full-time, career-oriented, northeast Ohio. Compensation commensurate with experience and training. Liberal fringe benefits, including professional liability insurance. Write: J. J. Cahill, M.D., 36001 Euclid Ave., Willoughby, Ohio 44094. Phone: 216/946-4546.

SURGEON: Board-certified, wants to slow down. Seeking position with minimum 3-months, noncontinuous vacation annually. Reply to Box 832 c/o Ohio State Medical Journal.

MEDICAL DIRECTOR & STAFF PHYSICIANS: County-owned-and-operated, long-term facility with skilled nursing, tuberculosis, pediatric, chronic illness, alcoholism detoxification and rehabilitation divisions. Full-time positions available immediately in 199-bed J.C.A.H. approved facility. Ohio State License required. Salary negotiable. For further information write to: Kathryn E. Shearer, Business Administrator, Molly Stark Hospital, Box 9122, Canton, Ohio 44711 or phone 216/875-5531.

LOOKING FOR A POSITION?
SEEKING AN ASSOCIATE?
Contact the OSMA Placement Service
600 S. High Street, Columbus 43215
Telephone: 614/228-6971

CAPE COD: Falmouth, Mass. Good investment. Two-bedroom condominium in wooded, private area. Near beaches, golf, etc. Harold Bach, R.E. 617/540-0707.

MARION, OHIO: Excellent opportunities in Central Ohio. Existing and new, solo, partnerships, or association practices available and seeking physician support. Top compensation— reliable cross coverage. Exceptionally attractive, 250-bed, well-equipped regional medical center hospital within walking distance from offices. Industry and agriculture support city/45,000; county/65,000; and total trade area/250,000. Excellent schools and residential areas. Fifty-minute, easy drive to Columbus. Active need for—

FAMILY PRACTICE
INTERNAL MEDICINE
OTOLARYNGOLOGY
PEDIATRICS
ORTHOPEDIC SURGERY
EMERGENCY MEDICINE
GENERAL SURGERY

We are seeking either rural or city-oriented physicians. Send C.V. or contact— ROBERT FLINT, Marion General Hospital, MARION, OHIO 43302 — or call 614/382-8211 or 382-3442 any time.

AMBULATORY CARE CENTER — EMERGENCY DEPARTMENT STAFF PHYSICIAN, ATHENS, OHIO: 20,000 annual patient visits. Flexible scheduling, minimum guarantee/monthly bonus, excellent fringes. Contact Eric Jenison, M.D., O'Bleness Memorial Hospital, Athens, Ohio 45701, or call toll-free 800/325-3982 for details.

FOR SALE: Hamilton steelbone cabinets, biscayne blue, like new. Treatment cabinet and waste receptacle— price $450. Call 216/381-9264.

FAMILY PRACTICE — RURAL PRACTICE: Northwest/central rural/agrarian community of 1200/1500 needs family practice physician. Practice could expand to cover 3000/3500 population area. No physician now practicing. Community will support. Major regional hospital within driving distance. Contact ROBERT FLINT, MARION GENERAL HOSPITAL, MARION, OHIO 43302, phone 614/382-8211 or 382-3442.

OSMA Placement Service Ads

In order to promote retention in Ohio of physicians who trained in the State, ***The Journal***, in cooperation with the OSMA Department of Field Service, offers classified advertising listings at no charge to physicians-in-training desiring to practice in Ohio. Persons eligible for this service must be graduates of Ohio medical schools and/or persons who are completing an internship or residency program at an Ohio institution. They must also be currently in a medical training program or in the United States Armed Forces (or some other U.S. government service).

All classified ads will be printed anonymously by use of box numbers in a special classified ad section of ***The Journal***. Replies to the ads will be channeled through the Department of Field Service, which will assist in the location process. (Replies are otherwise confidential.) Ads will be printed as frequently as space permits. (See previous issues of ***The Journal*** for additional listings.)



INTERNIST: Available July 1978. Desires location in community that is rural with metropolitan ties, suburban metropolitan, metropolitan or inner city and over 15,000 population. Eligible for specialty board June 1978. Prefers group/partnership but solo practice with guarantee will also be considered. Contact Box P-30 c/o Ohio State Medical Journal.

INTERNIST: With cardiology subspecialty including invasive cardiology. Currently available. Desires location in areas 1, 2, 3 or 5 in suburban metropolitan or metropolitan community with population of 50,000 to 500,000. Prefers group practice. Contact Box P-18 c/o Ohio State Medical Journal.

EMERGENCY PHYSICIAN: Available July 1979. Desires group practice in community that is rural with metropolitan ties with population of 15,000-50,000. Eligible for specialty board examination July 1979. Contact Box P-22 c/o Ohio State Medical Journal.

SURGEON: General with vascular subspecialty available July 1979. Desires group practice in community that is rural with metropolitan ties, suburban metropolitan, metropolitan or inner city and over 15,000 population. Eligible for specialty board June 1978. Contact Box P-29 c/o Ohio State Medical Journal.

OBSTETRICIAN / GYNECOLOGIST: Available July 1978. Desires community that is rural with metropolitan ties or suburban metropolitan with population 50,000 to 100,000. Prefers solo or small group practice. Eligible for specialty board examination July 1978. Contact Box P-12 c/o Ohio State Medical Journal.

SURGEON: General. Available July 1978. Desires location in area 3 in community that is rural with metropolitan ties, suburban metropolitan, or metropolitan. Population 50,000-100,000. Prefers group practice. Eligible for specialty board July 1978. Contact Box P-5 c/o Ohio State Medical Journal.

ANESTHESIOLOGIST: Currently available. Desires small group practice in metropolitan area with population 50,000-500,000. No preference as to area of state. Contact Box P-10 c/o Ohio State Medical Journal.

INTERNIST: With endocrinology subspecialty available July 1979. Will take specialty board examination in September 1978. Desires location in areas 1 or 4 in metropolitan community with population of 50,000 to 1 million. Interested in small group practice and part-time academic appointment. Contact Box P-31 c/o Ohio State Medical Journal.

PSYCHIATRIST: Also general medicine. Available July 1978. Desires location in suburban metropolitan, metropolitan, or inner city community in areas 1, 4, or 5. Population 15,000-1-million. Very flexible as to type of practice. Eligible for specialty board examination July 1978. Contact Box P-6 c/o Ohio State Medical Journal.

SEPTEMBER 1978
Volume 74, Number 9

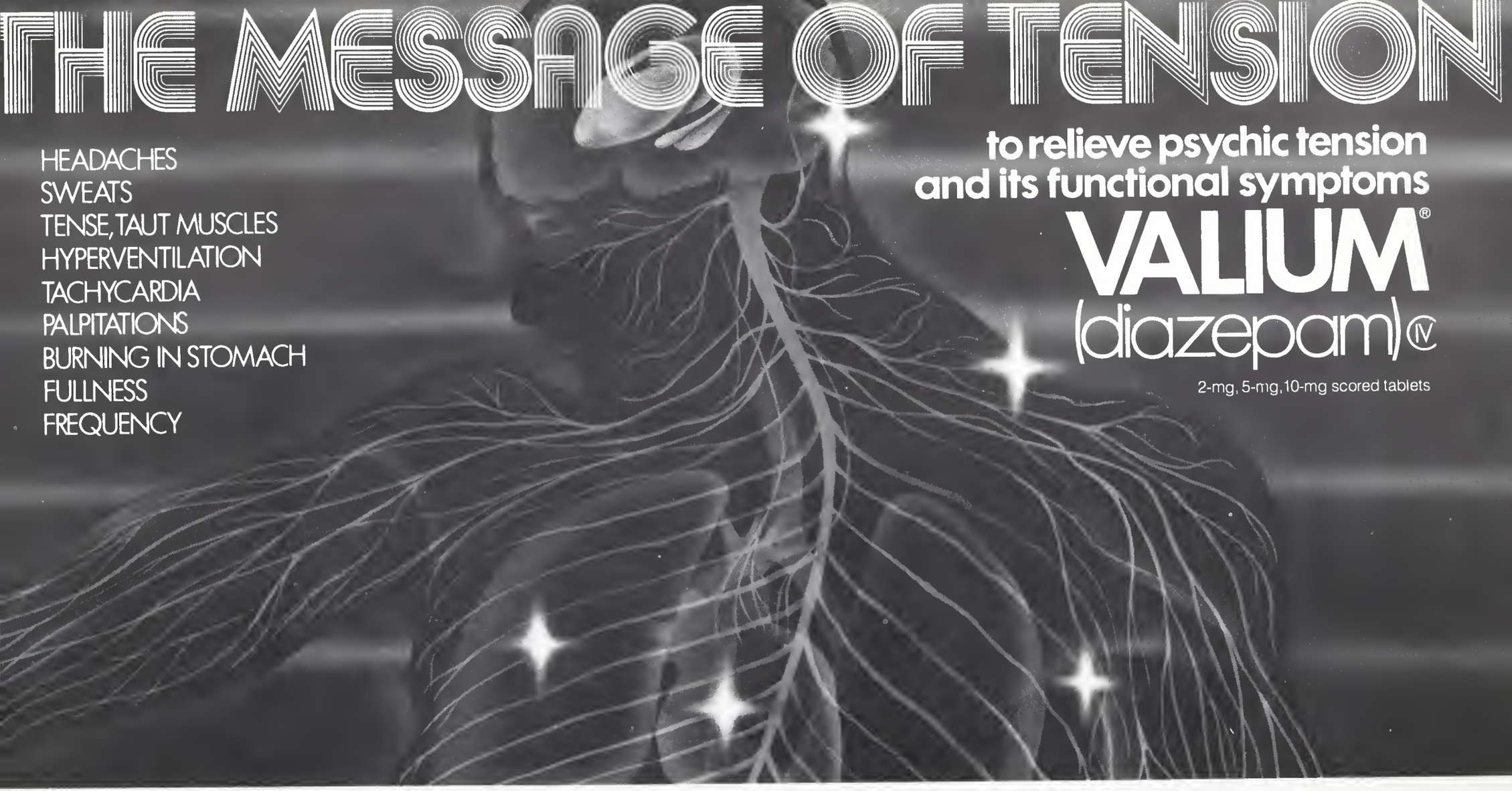
THE OHIO STATE Medical Journal



LIBRARY
U.C. SAN FRANCISCO
SEP 22 1978

PUBLISHED BY THE OHIO ST

THE LIBRARY
ACQUISITIONS DIVISION
UNIVERSITY OF CALIFORNIA, SAN FRAN
SAN FRANCISCO, CALIFORNIA 94143



VALIUM®(diazepam)

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).
The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

OSMA OFFICERS

President
JOHN J. GAUGHAN, M.D.
7911 Detroit Avenue
Cleveland 44102

President-Elect
THOMAS W. MORGAN, M.D.
P.O. Box 344
Gallipolis 45631

Past President
WILLIAM M. WELLS, M.D.
241 Hudson Avenue
Newark 43055

Secretary-Treasurer
ROBERT G. THOMAS, M.D.
630 East River Street
Elyria 44035

EDITORIAL STAFF

Consulting Medical Editor
Richard L. Meiling, M.D.

Managing Editor and Business Mgr.
Hart F. Page

Executive Editor and Executive Business Manager
Linda A. Porterfield

Editorial Assistant
Mary Lou Brady

Communications Editor
Rebecca J. Doll

Continuing Medical Education Editors
Gail E. Dodson
David C. Torrens

Federal Legislation Editor
Charles W. Edgar

Field Service Editor
Robert E. Holcomb

Government Relations Editor
Herbert E. Gillen

Health Education Editor
Robert D. Clinger

Membership Editor
Katherine E. Wisse

Organization Services Editor
Jerry J. Campbell

State Legislation Editors
D. Brent Mulgrew, Esq.
Richard A. Ayish

Address All Correspondence, Address Change, & Reprint Request (unless otherwise noted): Executive Editor, The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215. Phone: 614/228-6971.

Published monthly under the direction of The Council for and by members of The Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215, a scientific society, nonprofit organization, with a definite membership for scientific and educational purposes.

1979 Subscription: $15 per year, single copy $2 (outside U.S. $20 and $3).

Entered as second class matter July 5, 1905, at the Post Office at Athens, Ohio, under the Act of Congress of March 3, 1879. Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918. Second-Class Postage Paid at Athens, Ohio.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertisers must conform to policies and regulations established by The Council of the Ohio State Medical Association.

Publication office: 900 East State Street, Athens, Ohio 45701.

Printed by
The Lawhead Press, Inc., Athens, Ohio

VOL. 74 SEPTEMBER 1978 NO. 9

THE OHIO STATE Medical Journal

Clinical and Scientific Articles

THYROXINE-BINDING GLOBULIN DEFICIENCY: INNOCENT CAUSE OF LOW SERUM THYROXINE (T_4) LEVELS 563
Bonnie L. Typlin, M.D., Chicago; and Thomas E. Shaffer, M.D., Columbus

A CONGENITAL ANOMALY OF THE RIBS 567
Emil Gutman, M.D., Dayton

CLINICAL OBSERVATIONS FOLLOWING PAPAVERINE THERAPY 571
Gordon B. Snider, M.D., and Shashi A. Gogate, M.D., Lancaster

EVALUATION OF SURGICAL AND MEDICAL HOSPITALIZATIONS IN COLUMBUS, OHIO 575
William T. Paul, M.D., Columbus

CANCER EDUCATION SERIES: HOSPICE 579
Cornelia M. Dettmer, M.D., Ph.D., Cincinnati

Special Articles

MEDICAL MALPRACTICE ACT OF 1975 — A RETROSPECT 545
D. Brent Mulgrew, J.D., Columbus

AMPHETAMINE ABUSE 548
The Ohio State Medical Board

REPORT ON THE EXAMINATION OF FINANCIAL STATEMENTS FOR THE YEARS ENDED DECEMBER 31, 1976 AND 1977 551

Features

Continuing Education Programs..542
Obituaries.....558
News 581
Colleagues in the News.....584
Letter to the Editor.....585
Proceedings of the Council.....587
Journal Advertisers 590
Legislative Update — Federal...591
Classified Ads 593

COVER: Susan K. Clarke, wife of Oscar W. Clarke, M.D., Gallipolis, OSMA Past President and AMA Delegate from Ohio, created this woodcut, "Saw-Whet Owls." Mrs. Clarke was among the winners of awards presented to entrants in the 1978 OSMA Physicians' Art Show. Under the chairmanship of Ludolph H. van der Hoeven, M.D., Dayton, this show drew entries from physicians and their spouses. A complete list of award recipients appears on page 582 of this issue.

Copyright 1978. The Ohio State Medical Association. All material subject to this copyright may be photocopied for the noncommercial purpose of scientific or educational advancement.

THE OHIO STATE Medical Association Continuing Education Programs

Editor's Note: *The following are Category I courses offered in Ohio. Items for this listing come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in dates, places, or time occur too late to be corrected before publication. Physicians interested in a course are urged to contact the sponsoring organization to confirm the information listed. Sponsoring organizations may list Category I courses by contacting the OSMA Department of Continuing Medical Education or The Journal. Notification 90 days prior to the course would be appreciated. Due to space limitations, announcements may be published only once.* **See previous issues of The Journal for additional courses.**—*L.A.P.*

Continuing Courses

OSU COLLEGE OF MEDICINE CENTER FOR CONTINUING MEDICAL EDUCATION— CONFERENCES AND GRAND ROUNDS: Dates vary, weekly and monthly; Category 1 credit; contact: Robert B. Schweikart, Ph.D., A352 Starling Loving Hall, 320 West Tenth Avenue, Columbus 43210, phone: 614/422-4985.

SYMPOSIUM SERIES— DEPARTMENT OF GENERAL SURGERY: First and third Thursdays, July through June; St. Elizabeth Hospital Medical Center, Youngstown; 3-to-4 hours credit per lecture; fee: $150 for the series, $10 per lecture; contact: Rashid A. Abdu, M.D., St. Elizabeth Hospital, 1044 Belmont Avenue, Youngstown 44501, phone: 216/746-7211.

September 1978 Courses

OHIO VALLEY CONFERENCE ON DIABETES AND COMPLICATIONS: September 17, Jefferson Technical College, Steubenville; sponsor: Fort Steuben Foundation for C.M.E.; cosponsor: Fort Steuben Academy of Medicine; 6 credit hours; fee: $25, $10 Fort Steuben Foundation members, no charge Interns, Registered Nurses or Licensed Practical Nurses; contact: Fort Steuben Foundation, P.O. Box 217, Steubenville 43952.

FIFTH ANNUAL SYMPOSIUM ON PEDIATRICS FOR THE PRACTICING PHYSICIAN: September 22, 23, and 24; Commodore Perry Motor Inn, Toledo; 16 credit hours; fee: $125 physicians, $45 nurses, dietitians; contact: Howard S. Madigan, M.D., Medical College of Ohio at Toledo, C.S. 10008, Toledo 43699.

MEDICAL HORIZONS SYMPOSIUM ON "HYPERTENSION": September 27; Tangier Convention Center, Akron; sponsor: Akron General Medical Center; 5½ credit hours; fee: $20; contact: L. M. Provenzano, Akron General Medical Center, 400 Wabash Avenue, Akron 44307, phone: 216/384-6052.

SYMPOSIUM ON SCHIZOPHRENIA— THE CURRENT VIEW: September 27, Sheraton North Motor Inn, Columbus; sponsor: Harding Hospital; cosponsor: OSMA; 5½ credit hours; fee: $20, $6 for physicians-in-training and Harding staff; contact: Marcel Hundziak, 445 East Granville Rd., Worthington 43085, phone: 614/885-5381.

PREMATURE LABOR AND PREMATURITY: September 29; OSU Medical Administration Center Auditorium, Columbus; sponsor: OSU College of Medicine, Dept. of Pediatrics; cosponsor: OSU Center of Continuing Medical Education; 4 credit hours; contact: Rick Panzironi, University Hospital, Columbus 43210, phone: 614/422-7525.

October 1978 Courses

1978 ANNUAL CANCER SYMPOSIUM (Recent Advances in the Diagnosis and Treatment of Cancer): October 8, 8:30 AM - 4:30 PM; Fawcett Center for Tomorrow, Columbus; sponsor: American Cancer Society, Ohio Division, Inc.; cosponsors: Ohio State University Cancer Center and Northeast Ohio Cancer Center; application made for Category I credit; contact: American Cancer Society, Ohio Division, Inc., 1367 E. Sixth St., Cleveland 44114, phone: 216/771-6700.

CLINICAL RECOGNITION AND MANAGEMENT OF CARDIOVASCULAR DISEASE FOR PRACTICING PHYSICIANS: October 25-26; The Cleveland Clinic Foundation, Cleveland; 12 credit hours; fee: $100, $50 physicians-in-training; contact: Center for CME, The Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106, phone: 216/444-5696

SYMPOSIUM ON VOCAL AND LARYNGEAL DISORDERS: October 27-28; The Cleveland Clinic Foundation, Cleveland; 12 credit hours; fee: $125, $75 physicians-in-training; contact: Center for CME, The Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106, phone: 216/444-5696.

November 1978 Courses

CEREBRAL PALSY: CURRENT CONCEPTS IN DIAGNOSIS AND TREATMENT: November 1; Cleveland Clinic Foundation, Cleveland; 6 credit hours; fee: $50, $25 students and physicians-in-training; contact: Phillip Gard, Cleveland Clinic Educational Foundation; 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

FAMILY PSYCHIATRY: November 2; Holiday Inn, Lane Avenue, Columbus; guest speaker: John G. Howells, M.D., Ipswich, England; sponsor: OSU Center for Continuing Medical Education; cosponsor: OSU Dept. of Psychiatry; 6 credit hours; fees vary; contact: Jon Hollett, 320 W. Tenth Avenue, Columbus 43210, phone: 614/422-4985.

UNCOMMON COMMON DISEASES (Pediatric Clinical Faculty 8th Annual Symposium): November 2, Rainbow Babies and Childrens Hospital; Sponsor: Rainbow Babies and Childrens Hospital; cosponsor: Case Western Reserve University; 7 credit hours; contact: B. D. Clem, M.D., Pediatric Clinical Faculty Office, Rainbow Babies and Childrens Hospital, 2101 Adelbert Road, Room 117, Cleveland 44106, phone 216/444-1000.

IMMUNOLOGY IN CLINICAL PRACTICE: November 8-9; Cleveland Clinic Foundation, Cleveland; 12 credit hours; fee: $100, $50 students and physicians-in-training; contact Phillip Gard, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

TUMOR CONFERENCE: November 9, November 11; St. John Hospital, Cleveland; 1 credit hour each session; contact: M. S. Farooqi, M.D., Director of Medical Education, St. John Hospital, 7911 Detroit Avenue, Cleveland 44102, phone: 216/651-7000, ext. 394.



J. HARRY MOSHER, CLU
VICE PRESIDENT

CONSULT WITH . . .
The Professionals!

These T&S representatives provide professional service throughout the state to members of The Ohio State Medical Association.

Feel free to call the Turner and Shepard office nearest you for insurance counseling, advice, or information on the Association-sponsored coverages which we administer.

- **Group Term Life Plan**
- **Disability Income Protection Plan**
  (co-sponsored with many local medical societies)



JIM LEWIS
COLUMBUS



JOE VOLZ
CINCINNATI

TURNER & SHEPARD, inc.

AFFILIATED WITH ALEXANDER & ALEXANDER, INC.

Columbus, Ohio 43215	17 South High Street	Phone (614) 228-6115
Akron, Ohio 44313	3090 West Market Street	Phone (216) 434-5000
Cincinnati, Ohio 45241	4015 Executive Park Drive	Phone (513) 563-4220
Cleveland Ohio 44134	1440 Snow Road	Phone (216) 741-4466
Toledo, Ohio 43606	3450 West Central Avenue	Phone (419) 535-0616



SHERRY RAMSEY
COLUMBUS



MAURY JONES, CLU
CINCINNATI



ED GIACO
CLEVELAND



MIKE SEKERAK
CLEVELAND



BOB ROEHL
TOLEDO



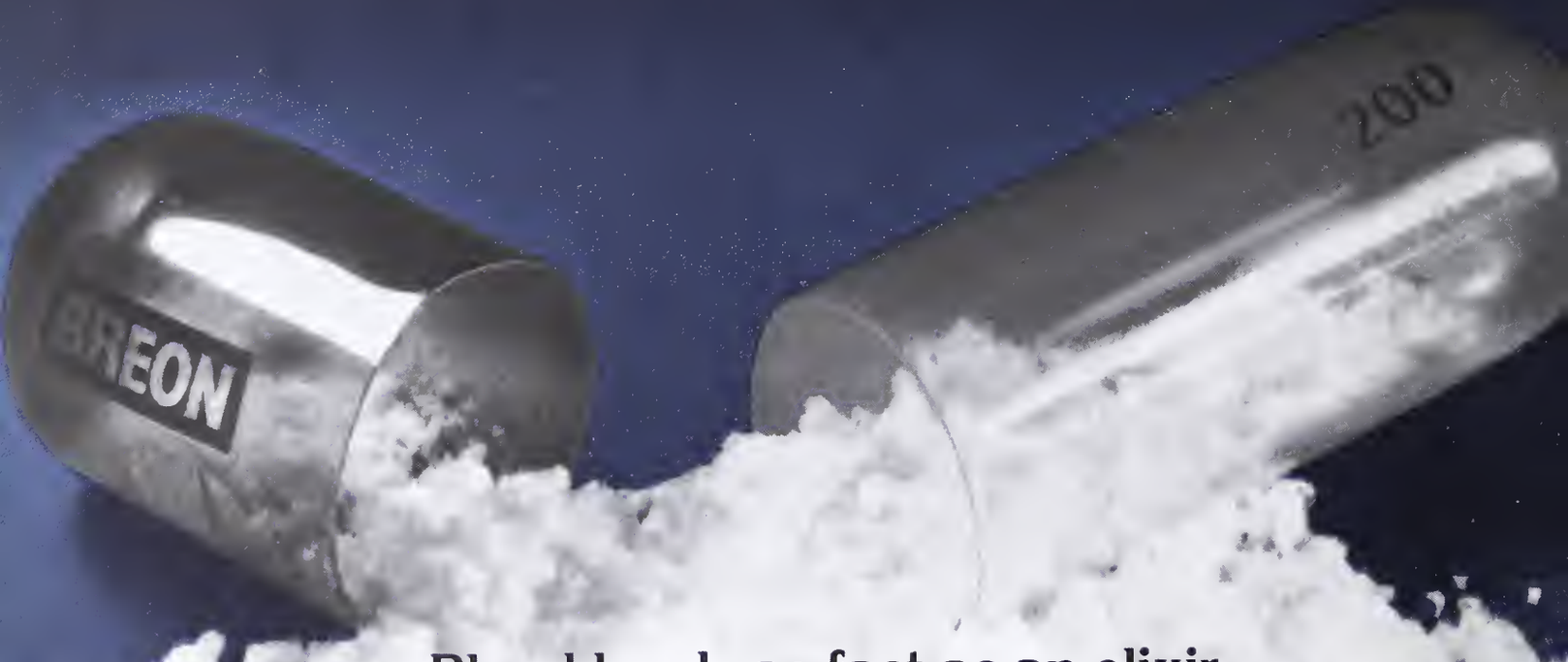
CLIFF MOSHER
AKRON-CLEVELAND

A Difference in Theophylline Therapy

micro-pulverized

BRONKODYL® Capsules

brand of theophylline, USP anhydrous



- **Blood levels as fast as an elixir**
- **With minimal gastric irritation***

*Please see complete prescribing information, a summary of which follows.

DESCRIPTION:
Each green and white hard gelatin capsule contains theophylline USP anhydrous, 200 mg., in a micro-pulverized form. Each brown and white hard gelatin capsule contains 100 mg. The elixir contains 80 mg. theophylline per 15 ml. in a 20% alcohol elixir (approximately 20 calories, 0.9 gm carbohydrate per tablespoonful).

ACTION: Theophylline is a methylxanthine which relaxes the smooth musculature of the bronchioles through its inhibition of the conversion of cyclic adenosine monophosphate to adenosine monophosphate by phosphodiesterase. It also has diuretic, cardiotonic, and CNS stimulant effects.

INDICATIONS: Bronkodyl is indicated for symptomatic relaxation of bronchiolar spasm in the chronic obstructive bronchopulmonary diseases; e.g., bronchial asthma, chronic bronchitis and pulmonary emphysema.

CONTRAINDICATIONS: Bronkodyl is contraindicated in persons known to have had serious idiosyncratic responses to theophylline, its salts, or the other methylxanthines, theobromine, or caffeine and may be contraindicated in peptic ulcer.

WARNINGS: All methylxanthines should be used with caution in children and in others who are currently taking bronchodilator products, especially in rectal dosage form, which may contain theophylline or related drugs.

USAGE IN PREGNANCY: Although theophylline has been used for many years, with no evidence of adverse fetal effect or teratogenicity, its safety in pregnancy has not been established. Therefore use of Bronkodyl during lactation or in women of childbearing potential requires that possible benefits of the drug be weighed against possible hazards to fetus or child.

PRECAUTIONS: Bronkodyl should be used with caution in patients with cardiac or circulatory disease.

ADVERSE REACTIONS: Gastrointestinal: Epigastric distress, nausea, vomiting. Cardiovascular: palpitations. CNS: Insomnia, restlessness, irritability, convulsion.

DOSAGE AND ADMINISTRATION: Adults: Usual dosage of Bronkodyl is 200 mg. every 6 hours (four doses in each 24 hours). This dosage may be adjusted to reflect individual clinical response as an indication of slow or rapid metabolism of the drug. If adverse reactions are encountered, each dose may be reduced, or the interval between doses may be lengthened, or both. If clinical response is not satisfactory, indicating possible rapid inactivation of the drug, dosage may be gradually increased to achieve the desired response. In some instances of either too slow or too rapid metabolism, plasma levels of theophylline should be determined and dosage adjusted accordingly to achieve levels above 10 mcg/ml, but not to exceed 20 mcg/ml.

Dosage in Children: Usual dosage should be based on administration of 10 mg per kg per 24 hours, divided in 4 doses per day, given every 6 hours. As this may not be possible with use of the capsules, Bronkodyl elixir may be used. Theophylline saliva levels (approximately 60% of simultaneous blood levels), may facilitate dosage adjustments, especially in children, to obtain appropriate response.

HOW SUPPLIED:
Bronkodyl 100 mg., brown and white capsules in 100's, Code #1831.
Bronkodyl 200 mg., green and white capsules in 100's, Code #1833.
Bronkodyl Elixir, 80 mg. per 15 ml, in pints, Code #1835.

BREON LABORATORIES INC.
90 Park Avenue, New York, N.Y. 10016

Medical Malpractice Act of 1975 — A Retrospect

D. Brent Mulgrew, J.D., Director
OSMA Department of State Legislation

Less than four years ago, Ohio was one of many states caught in the midst of a "medical malpractice crisis." Although there are some who still contend that the entire crisis was contrived by the medical profession and/or the insurance industry, both the experiences of physicians and statistical analyses of the period indicate otherwise. Briefly, this article will review the changes in the medical malpractice environment in Ohio from 1975 to the present.

The number of medical professional negligence (malpractice) claims had been increasing steadily from 1970 to 1974. Settlements and awards were growing in volume and amount, and the cost of premiums for medical professional liability insurance was rising rapidly. In 1974, there was a significant reduction in the availability of malpractice insurance for physicians and hospitals throughout Ohio and nationwide. Even though physicians unwillingly paid the increased premiums, many insurance companies felt that there still was too much risk involved with too little financial gain; and they simply did not renew their lines of medical professional liability insurance.

As more and more physicians became aware of the difficulty of obtaining and then retaining their medical professional liability insurance, they began to practice medicine "defensively." In other words, they were forced to order tests, consultations, and observations of patients for every possible symptom and side-effect in order to make sure that there could not be even a subtle hint of less-than-adequate care. The results were increased medical and surgical costs to the patient.

Omnibus Medical Malpractice Act

In 1974, this situation became a crisis. Both the cost factor and the availability of malpractice insurance assumed a greater importance than ever before to the physician and to the consumer, who ultimately paid the increased costs of malpractice insurance premiums and of defensive medicine. In 1975, the Ohio Legislature responded to this crisis with Amended Substitute House Bill 682, the omnibus medical malpractice bill. HB 682 confronted three major issues: availability of medical professional liability insurance, disciplining of physicians through both peer- and state-licensing-board review, and the Ohio tort system as applied to medical malpractice cases.

The bill managed to deal with these issues— at least on a short-term basis. Currently, the general crisis atmosphere of 1975 has been reduced; medical professional liability insurance is available to physicians (although it still is expensive); and according to some nationwide studies, the growth in the number of medical malpractice claims has been slowed somewhat. However, not enough time has elasped to evaluate whether or not this reduction in the growth of claims is permanent. Studies by the National Association of Insurance Commissioners have shown an increase in the size of malpractice awards even though there has been a decrease in the number of claims.

Availability of Insurance

One of the major problems resolved by HB 682 was the availability of medical professional liability insurance. By creating the Ohio Medical Professional Liability Underwriting Association — also called the Joint Underwriting Association (JUA)— the Legislature guaranteed a system of providing malpractice insurance to physicians and hospitals. At the end of its first year of operation (July 1976), the JUA had insured 3,040 physicians/medical corporations/partnerships with primary first-dollar coverage ($100,000/$300,000) and 3,711 with excess coverage (amount of insurance more than primary coverage up to $1 million). The JUA also had received applications from 176 hospitals for primary and/or excess coverage. These numbers graphically illustrate that providing some form of malpractice insurance to physicians was a necessity, because physicians insured by the JUA insurance system are assessed a 100% surcharge in addition to the basic premiums. This surcharge creates a Stabilization Reserve Fund (SRF) for future payment of claims if the policy premiums charged prove inadequate.

The SRF surcharge was a legislative "compromise" which the physicians accepted in order to insure avail-

ability of medical professional liability insurance. As of July 28, 1978, the SRF had collected $23,250,000. By selling a "claims made" policy, the JUA has been able to limit its reserves for the claims asserted against physicians to $2,267,600 and against hospitals to $846,300. As of July 28, 1978, the JUA had received 564 claims against physicians and 341 against hospitals, an increase of 144 and 102 claims respectively since February 28, 1978.

Although the JUA handled the immediate problem of availability, physicians felt the need for an alternative to government-sponsored malpractice insurance. Since the inception of the JUA, the physicians' insurance market has expanded with the creation of physician-owned insurance companies throughout the United States. Nationwide, there are 16 to 18 of these physician-owned companies providing an alternative source for medical professional liability insurance. In Ohio, the Physician's Insurance Company of Ohio (PICO)— created by the Ohio State Medical Association— will be able to provide its physician-owners with actuarial data concerning claims and losses. Ohio physicians will be able to ascertain that their premium rates are being developed with strict regard to their own claims and cost experience.

Continuing Medical Education

Another problem tackled by HB 682 was that of continuing medical education (CME). The bill mandates that each physician complete 150 hours of CME every three years in order to have his/her license renewed. The Legislature felt physicians who kept up with new medical techniques and practices were less likely to be committing acts of malpractice. To pay for this increased review, license renewal fees were increased and numerous conditions for revoking a license were clearly outlined to the State Medical Board in Section 4732.22 (B) 1-18 O.R.C., otherwise known as "18 ways to lose your license."

Medical Malpractice Litigation

The most controversial provisions of HB 682 deal with the procedures relating to medical malpractice litigation. The mandatory pretrial arbitration required by the statute was seen by many as a way of screening out frivolous malpractice cases and encouraging settlement of valid cases prior to trial. While this mandatory, but nonbinding, arbitration is still under constitutional challenge in Ohio, the supreme courts in several other states (including most recently Maryland) have held similar statutes constitutional.

The implementation of Ohio's nonbinding pretrial arbitration has varied greatly across the state. While some common pleas courts spent much time and effort setting up systems and procedures to implement mandatory arbitration, these systems remain unused for the most part. Many courts are not enforcing the required arbitration hearings; some have stayed the proceedings pending the outcome of constitutional tests; and others randomly are ordering arbitration when one of the participants requests it. A number of lawyers for both the plaintiff and the defense question the benefits of the present procedures. Franklin County's system for arbitrator selection and the conduct of hearings now is being implemented. The Franklin County system has been copied by several other common pleas courts, but only when the constitutional challenges finally are resolved can a fair analysis of the legislation's impact be made.

House Bill 682 also tried another approach to reduce litigation— binding arbitration. However, the statutory permission for these agreements executed prior to the medical event has, by and large, gone unused. There have been several attempts by both government and private committees to test and implement the binding arbitration option; but at this point, no system has been developed.

In regard to litigation, another aspect of the omnibus medical malpractice bill relates to the use of traveling "expert witnesses" with little clinical experience. Describing qualifications for "medical claim experts," this new statute has been accepted by several trial courts. Section 2743.43 O.R.C. provides that a medical expert must be a licensed physician and spend at least three-fourths of his/her time in clinical practice or instruction. However, the new rules of evidence proposed by the Supreme Court, but rejected by the Ohio Legislature, could have altered this requirement by placing solely with the trial judge the decision of a witness's competency.

Consent Form

Attorneys who have physician clients may also find themselves involved in another aspect of medical law— that of drafting a valid consent form for use by the physician. HB 682 attempted to increase physician-patient communication by mandating a consent form which met certain guidelines. Section 2317.54 O.R.C. included an optional consent form that met specified guidelines. However, a controversy developed when several hospitals tried to mandate the use of the statutory form, which was difficult to use and often lacked essential information for certain cases. The Legislature discovered that the form did not work and repealed it in HB 213 passed in 1977. The provision for a presumptively valid form remains in the statute, but it is the responsibility of the physician and his attorney to develop a form that meets the requirements in order to get the benefit of that presumption. Incidentally, neither HB 682 nor HB 213 changed the Ohio common law regarding informed consent. (See *The Journal,* Vol. 73, No. 12, page 798 and Vol. 72, No. 4, page 210.)

Countersuits

Probably the least controversial section in all of HB 682 concerns the elimination of the dollar reference in the *ad damnum*. Both professions seem to agree that this was often inflammatory and unnecessary. Yet, this provision is being ignored. Attorneys who include a dollar demand in the complaints they draft simply are not

following the statute's requirements. Moreover, this disregard for a law, especially one which is stated so clearly, frequently causes the physician to question the ethics, as well as the competence, of the attorney filing the complaint against him/her.

Sometimes, such practices lead the physician to file a countersuit— a response to the malpractice situation that was not envisioned in HB 682. Physicians who feel they have been sued wrongly and without merit are countersuing both the attorney and the client with greater frequency. An excellent analysis of countersuits was completed recently by James Ready, partner in the firm Knepper, White, Arter, and Haddon in Columbus. His conclusion was that while the pursuit of a countersuit in Ohio may be difficult under present Ohio law, the pressure for change is growing. In the future, attorneys— perhaps more conscious of time-consuming and expensive countersuit litigation— may be reviewing more closely questionable cases prior to filing.

Summary

In conclusion, the statutory changes in Am. Sub. HB 682 resolved the immediate crisis of insurance availability. In addition, the bill requires compilation of continuing medical education credits and increased power by the State Medical Board to review and revoke licenses. These provisions have been effective in achieving their goals. For the most part, the success of the changes in the medical malpractice litigation system is still open to question. The lack of implementation of several of the provisions and, in many cases, the ignoring of the statute's requirements during the constitutional challenges, have made evaluation of the impact of these sections very difficult. The reduction in the growth of the number of claims during 1976-1977 may be attributed, in part, to HB 682; but the long-term potential for another legislative crisis still exists.

Listening to the news and reading the papers today, it is not at all uncommon to hear President Carter and others making some rather unflattering remarks about both the medical and legal professions. These comments began not long after an American Medical Association physician asserted that 5% of all doctors are incompetent and continued with the comments of Supreme Court Justice Burger that 50% of all trial lawyers are incompetent.

The fact is that both professions have come under strict public scrutiny since 1975. In addition to the actual legal implications, perhaps one of the things to be learned from HB 682 is that such problems are not unique to physicians and that the increase in allegations of attorney malpractice and incompetence may someday force the legal profession into a position similar to that in which the medical profession found itself in 1975. ☆☆☆

we can provide some form of health insurance to . . .

99%

of OSMA members—regardless of health history

Comprehensive protection is available for you and your family with the OSMA sponsored Hospital Confinement Insurance Plan, comprehensive Major Medical Insurance and the Excess Major Medical Insurance Plan. Also available to Ohio physicians are Disability Income Coverage, Practice Overhead Expense Coverage, Life Insurance and Accidental Death, Dismemberment and Disability Insurance. Choose the plans that fill your insurance needs and send the coupon today for complete details. Or better yet for immediate information, call us collect!

Spencer W. Cunningham
DANIELS-HEAD & ASSOCIATES, INC.
Daniels-Head Building
Portsmouth, Ohio 45662
Telephone 614/354-4561

I have checked the plans in which I am most interested. Please send me complete details on how I can take advantage of this high value insurance protection at low group rates.

OSMA SPONSORED PLANS
- ☐ HOSPITAL CONFINEMENT INSURANCE PLAN
- ☐ COMPREHENSIVE MAJOR MEDICAL INSURANCE
- ☐ EXCESS MAJOR MEDICAL INSURANCE

ALSO AVAILABLE TO OHIO PHYSICIANS
- ☐ DISABILITY INCOME PROTECTION
- ☐ ACCIDENTAL DEATH, DISMEMBERMENT and DISABILITY INSURANCE
- ☐ PRACTICE OVERHEAD EXPENSE PROTECTION
- ☐ LIFE INSURANCE

Name_____
Address_____
City_____
State_____ Zip_____

A Discussion —
The Ohio State Medical Board on

Amphetamine Abuse

In December 1977, Peter B. Bensinger, Administrator of the U. S. Drug Enforcement Administration, outlined statistics which should concern every physician in Ohio.[1] In his statement, Mr. Bensinger indicated that theft reports to the Drug Enforcement Administration revealed that 3.8 million dosage units of amphetamines were stolen in the United States during the first nine months of 1977. As large as the number of thefts might seem, it is even more alarming that reported thefts account only for an estimated 10% of amphetamines actually diverted to illicit use. The remaining 80% are diverted primarily through promiscuous scriptwriting physicians, forged prescriptions, illegal sales, and dispensing "fat clinics."

Mr. Bensinger further stated that although the dimensions of the amphetamine/methamphetamine abuse problem are difficult to pin down with hard data, "the November 1976 Federal Strategy Paper notes the 'extremely high use rates of young adults aged 18-25' in the Fall/Winter 1975/76 National Survey of Drug Use and cites use of amphetamines in that age group as second only to marijuana among the principal drugs of abuse."[1]

Ohio is not immune from drug abuse problems. The State Medical Board perceives apparent misuse of amphetamines or methamphetamines in treatment by physicians as a primary problem. Such misuse can result in diversion of licit drugs to illicit purposes.

The Medical Board continually is confronted with situations where physicians who prescribe or dispense large numbers of amphetamines give inadequate physical examinations, prescribe or dispense amphetamines to a patient over a prolonged period of time, fail to individualize weight programs, overprescribe in the amount of dosage, or prescribe amphetamines inappropriately with other antagonistic drugs.

Treatment for Obesity

Many of these situations occur in conjunction with physicians who regularly use amphetamines or methamphetamines to treat patients for obesity. Few physicians in Ohio probably realize that the U. S. District Court for the Northern District of Ohio, in a Consent Decree for Declaratory Judgment and Order of Permanent Injunction involving an Ohio physician, has declared "the medical diagnostic requirements, tests and procedures and medically accepted standards that must be met and performed by any physician involved in treating patients for obesity and dispensing of scheduled anorectic drugs which are controlled substances . . ."[2]

The Court states that medical standards are not met where such controlled drugs are dispensed and prescribed to a large number of patients as a standard treatment, nor are they met when a physician of the patient only takes the pulse, blood pressure, weight, performs a stethoscopic examination, has a five-minute personal interview with the patient, has only a casual concern as to possible dependency or addiction of the patient to anorectic drugs, and then delivers a recommended diet to the patient on any office visit.

In particular, the court states,

> Since no medical authority disagrees over the need to individualize the treatment of obesity, it follows that in a practice where a large number of patients are treated for obesity, there will be significant variations in the approach to treatment. It is prima facie improper for a single approach to be used. It is improper that the prescribing and dispensing of anorectic drugs be included as a routine part of the treatment of obesity. In other words, it is not proper for the physician dispensing and prescribing anorectic controlled drugs to adopt a unitary approach to the treatment of obesity in that no standard approach to treatment exists.[2]

Although the courts have made such a declaration, much remains to be done in enforcement areas. The Medical Board will continue to be alert to the prescribing or dispensing of large numbers of amphetamines through information provided by Drug Enforcement Administration agents, State Board of Pharmacy investigators, as well as its own investigators. The Medical Board will continue to hold informal conferences in situations where it is apparent that a physician may not understand the abuse problem or may be able satisfactorily to explain a large number of drugs being dispensed to a few patients.

House Bill 682

Some state boards have made specific declaratons as to amphetamine usage. For instance, the New Jersey State Board of Medical Examiners recently stated that

> . . . it is now, and has been for a substantial number of years, generally recognized throughout the medical community that the only medically recognized uses of amphetamines and its group of sympathomimetic amines for a period in excess of 14 days and other than in the course of controlled psychiatric therapy by an institution or physician qualified to provide such therapy are:
>
> 1. Narcolepsy . . .
> 2. Minimal brain dysfunction . . .
> 2. Obesity: Usual adult dose 50 to 30 milligrams per day in divided doses for a period not normally to exceed six weeks duration . . .[3]

Although a "ban" on amphetamines has also been announced by the Wisconsin Medical Examining Board, blanket declarations that a physician who violates a "ban" can be charged with unprofessional conduct are not necessary in Ohio for the State Medical Board to take disciplinary action. House Bill 682, popularly known as the Malpractice Act, changed the disciplinary standards in Ohio from those of "gross immorality" or "grossly unprofessional and dishonest conduct" to 18

specific offenses. Under the new language, it becomes possible to suspend or revoke a practitioner's license for "failure to employ acceptable scientific modalities in the selection of drugs or other modalities for treatment of disease"[4] or "selling, prescribing, giving away, or administering drugs for other than legal and legitimate therapeutic purposes or conviction of any federal or state law regulating the possession, distribution, or use of any drug,"[4] making it much easier for the State Medical Board of Ohio to take appropriate action against practitioners who misuse amphetamines. At the time of this writing, the State Medical Board of Ohio has formally charged 23 practitioners with violations of these standards, and will continue to bring charges against practitioners using inappropriate prescribing and dispensing habits.

Summary

But whatever efforts are undertaken by the Medical Board, or any other local, state, or federal agency, controlling diversion of licit amphetamines is largely dependent upon you, the individual practitioner. Rather than waiting for government agencies to set particular practice standards, you can help in developing appropriate standards through your own professional societies and associations. Make your fellow physicians aware of problems by assisting in the preparation or distribution of educational materials. Report known instances of promiscuous prescribing or dispensing to the State Medical Board. Offer to testify at disciplinary hearings, either as a witness or an expert. Remember that continued activities by the few "bad actors" reflect poorly upon both you and your profession. Look closely at your own prescribing and drug security practices. Don't presign prescriptions. Don't have your DEA (BNDD) number printed on your prescription blanks. Instead, write it in when you prescribe controlled substances. Be suspicious when a new patient suggests or requests you prescribe a specific drug that is subject to abuse. Select a drug, whenever possible, that possesses the least abuse potential.

Because of widespread abuse, the Drug Enforcement Agency is developing a comprehensive suppression program against clandestine laboratories manufacturing amphetamines and methamphetamines.[1] The more successful these efforts against clandestine laboratories become, the greater the abuser demand pressure will be on you, the physician, to provide them.

References

1. Statement of Peter B. Bensinger, Administrator, Drug Enforcement Administration, at the Food and Drug Administration Hearing on Amphetamines, December 2, 1977, pp 2-3, 5.
2. *U.S. vs Zwick* (C76-23-A, April 27, 1976), consent decree for declaratory judgment and order of permanent injunction, pp 2-3.
3. Letter from Edwin H. Albana, M.D., President, New Jersey State Board of Medical Examiners, to Medical Society of New Jersey, in *Medical Society of New Jersey Newsletter,* February 1978.
4. *Ohio Revised Code,* Section (B), pp. 2-3.

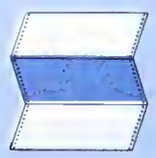
☆☆☆

Get PAID.

Time and time again, Medical Data Systems® users report: (1) substantial reductions in outstanding accounts receivable, (2) accelerated cash flow, (3) elimination of missing charges, and (4) faster turn around on third-party claims. Data processing services are more than fancy reports. MDS can be the difference between getting paid and not getting paid. And that's a good business basic.

S-Tek Computer Services — The Data Processing Tailors

MEDICAL DATA SYSTEMS®



Call or write our Sales Department for more information.

S-Tek
COMPUTER SERVICES, INC.
P.O. BOX 328 TERRE HAUTE, IN 47808 812-232-1385

Medical Data Systems® a registered trademark of S-Tek Computer Services Inc.

We create impressions...

First impressions for physicians' waiting rooms. As in the contemporary style shown here, we will design a waiting room that reflects your concern for quality, serenity and most importantly, your patients' total comfort. We will blend style and function in every other room of your office as well. Create an impression . . . call us. We're Medical Interiors, a division of the Wendt-Bristol Company.



medical interiors
a division of THE WENDT-BRISTOL CO.
1107 dublin road p.o. box 144
columbus, ohio 43216

☐ please send a brochure explaining your design concepts.
☐ I'm interested in learning more about MEDICAL INTERIORS.

the wendt-bristol company

NAME

ADDRESS

CITY STATE ZIP

OSMJ-9/78

Report on the Examination of Financial Statements for the Years Ended December 31, 1976 and 1977

Accountants' Report

The Committee on Auditing and Appropriations
Ohio State Medical Association
Columbus, Ohio

We have examined the balance sheet of Ohio State Medical Association at December 31, 1977 and 1976 and the related statements of operations and net worth and changes in financial position for the years then ended. Our examination was made in accordance with generally accepted auditing standards and, accordingly, included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

As described in Note 3 to the financial statements, the Association has receivables from a nonprofit corporation of $75,217. Recoverability of the receivables is dependent upon the successful development and marketing of a peer review system for the medical profession. Because of the aforementioned condition, recoverability of the receivables is not determinable.

As described in Note 7 to the financial statements, the Association is the defendant in a legal action which alleges violations of federal and state antitrust laws. Because of the present status of the litigation, the ultimate liability, if any, cannot now be determined.

In our opinion, subject to the effects, if any, on the financial statements of the ultimate resolution of the matters discussed in the preceding paragraphs, the aforementioned financial statements present fairly the financial position of the Ohio State Medical Association at December 31, 1977 and 1976 and the results of its operations and changes in financial position for the years then ended, in conformity with generally accepted accounting principles applied on a consistent basis.

Coopers & Lybrand

Columbus, Ohio
March 15, 1978

Ohio State Medical Association Balance Sheet, December *31, 1977 and 1976*

ASSETS	1977	1976
Current assets:		
Cash	$ 565,630	$ 379,667
Accounts receivable	24,187	42,785
Investment, Physicians Insurance Company of Ohio (PICO), at cost (Notes 9 and 13)		453,000
Prepaid expenses, including $16,938 in 1976 of unamortized pension costs	19,716	34,595
Total current assets	609,533	910,047
Other assets:		
Due from Medical Advances Institute (Note 3)	75,217	75,217
Investments:		
General Trust Fund, at cost which approximates market	43,598	43,403
Ohio Medical Indemnity, Inc., at cost (Notes 6, 7 and 10)	56,000	56,000
Physicians Insurance Company of Ohio (PICO), at cost (Notes 9 and 10)	100,000	100,000
Other		1,857
	274,815	276,477
Property and equipment, at cost (Notes 1 and 2):		
Land	200,987	200,987
Building	517,042	514,020
Furniture and fixtures	92,225	117,972
	810,254	832,979
Less accumulated depreciation	(81,626)	(95,807)
	728,628	737,172
	$1,612,976	$1,923,696

(Audit continued on next page)

LIABILITIES AND NET WORTH	1977	1976
Current liabilities:		
Accounts payable	$ 145,609	$ 85,438
Current portion, term debt (Note 2)	18,018	16,638
8¼%, 60-day note payable, bank (Notes 9 and 13)		453,000
Accrued interest	979	5,344
Other current liabilities	132,696	138,578
Total current liabilities	297,302	698,998
Term debt (Note 2)	128,890	146,907
Deferred income:		
Annual membership dues (Note 1)	68,050	65,575
Life membership dues (Note 1)	40,250	35,850
Other	3,940	4,131
	112,240	105,556
Net worth (Notes 7 and 12)	1,074,544	972,235
	$1,612,976	$1,923,696

(The accompanying notes are an integral part of the financial statements.)

Statement of Operations and Net Worth

For the Years Ended December 31, 1977 and 1976

	1977	1976
Income:		
Membership dues (Note 1)	$1,268,178	$1,232,535
Membership solicitations—Malpractice Research Fund (Note 11)	600	238,231
Exhibit fees	21,420	22,440
Annual meeting	15,083	5,453
Fees for collection of AMA dues	13,061	11,444
CME accreditation and courses	2,643	7,407
Ohio State Medical Journal (Note 8)	83,265	62,609
Interest on savings accounts and certificates of deposit	42,934	36,293
General trust income	194	1,367
Rental income	12,484	12,569
Other	6,127	3,299
	1,465,989	1,633,647
Departmental operating expenses:		
Administration	281,929	291,942
Convention Coordinator and CME	166,724	160,085
Health Education	68,133	55,534
Field Service	62,460	57,206
Financial and Membership	159,633	104,110
Government Medical Care	65,458	60,949
Ohio State Medical Journal (Note 8)	197,953	169,691
Organizational Services	69,300	45,698
Federal legislation and public policy	104,048	116,864
State Legislation	95,850	72,178
Communications	59,469	
Malpractice Research Fund (Note 11)	32,723	162,450
	1,363,680	1,296,707
Net income from operations	102,309	336,940
Net worth, beginning of year	972,235	635,295
Net worth, end of year	$1,074,544	$ 972,235

(The accompanying notes are an integral part of the financial statements.)

Statement of Changes in Financial Position

For the Years Ended December 31, 1977 and 1976

	1977	1976
Source of funds:		
From operations:		
Net income	$102,309	$336,940
Depreciation and amortization not requiring working capital, including $63,800 in 1976 relating to pension costs	22,997	87,132
Increase in deferred income (net of $1,850, amortization of life memberships)	6,684	
Decrease in unamortized pension cost, net of charges to operations not requiring working capital		(63,800)
Other	1,857	1,856
	133,847	362,128
Application of funds:		
Acquisition of property and equipment	14,453	6,329
Increase in General Trust Fund	195	1,366
Repayment of term debt	18,017	91,600
Decrease in deferred income (net of $1,600, amortization of life memberships)		31,419
Investment in Physicians Insurance Company of Ohio		100,000
	32,665	230,714
Increase in working capital	$101,182	$131,414
Changes in the components of working capital:		
Increase (decrease) in current assets:		
Cash	$185,963	$ 90,518
Accounts receivable	(18,598)	21,243
Investment, Physicians Insurance Company of Ohio	(453,000)	453,000
Prepaid expense and unamortized costs	(14,879)	(53,678)
	(300,514)	511,083
Increase (decrease) in current liabilities:		
Notes payable to bank	(453,000)	453,000
Accounts payable	60,171	26,966
Current portion, term debt	1,380	(73,762)
Accrued interest	(4,365)	3,572
Other current liabilities	(5,882)	(30,107)
	(401,696)	379,669
Increase in working capital	$101,182	$131,414

(The accompanying notes are an integral part of the financial statements.)

Notes to the Financial Statements

1. **Accounting Policies**

The following is a summary of certain significant accounting policies followed in the preparation of the financial statements. The policies conform to generally accepted accounting principles and have been consistently applied.

a. The Association provides for depreciation on the straight-line and declining-balance methods in amounts adequate to amortize costs over the estimated useful lives of the assets. Depreciation charged to operations amounted to $22,997 in 1977 and $23,332 in 1976.

b. *Deferred Membership Dues.*— Income from annual membership dues is recognized in the calendar year to which they apply. Life membership dues income is recognized over 25 years of active practice of the life membership participants.

c. *Prepaid Pension Costs.*— At the inception of its qualified pension plan during 1969, the Association fully funded all costs of the plan, which amounted to $386,900. The prepaid costs are being amortized on an approved actuarial method each year, such annual provision consisting of normal cost plus 10% of the frozen initial liability (past service costs), reduced by interest on the unamortized prepaid costs.

(Audit continued on next page)

2. Term Debt
Term debt at December 31, 1977 consists of an 8% mortgage loan payable in monthly installments of $2,427, including interest, collateralized by land and building, and due July 1, 1984.

3. Due from Medical Advances Institute
The Association has advanced $75,217, primarily noninterest bearing, to Medical Advances Institute (MAI), an Ohio corporation not for profit, to support this organization's development of a peer review system for the medical profession. The recovery of funds advanced to MAI is generally dependent upon the successful development and marketing of the system, which is currently in the developmental stage. The Association believes the system will be successful; however, there has been insufficient operating history and experience to determine the recoverability of the above amount.

4. Pension Plan
The Association has a salaried employee's pension plan covering substantially all of its employees. (The Association funded the entire cost of the plan at its inception in 1969—see Note 1). The pension costs for the year 1977 was $76,519 and for 1976 was $63,800. The pension costs include normal costs of $68,758 for 1977 and $59,095 for 1976, minimum past service costs of $8,438 for 1977 and $8,545 for 1976; reduced by interest of $677 for 1977, and $3,840 for 1976 on the unamortized prepaid pension costs. At December 31, 1977 and 1976, the actuarially computed value of vested benefits exceed plan assets by $210,513 and $135,500, respectively.

The Association has basically completed its amendment of the pension plan in compliance with the Employee Retirement Income Security Act of 1974 (ERISA), and the pension costs for 1977 and 1976 reflect such amendment changes.

5. Leases
The minimum rental commitments of the Association under all non-cancelable leases were as follows at December 31, 1977:

	1978	1979	1980	1981
Equipment	$ 8,162	$1,560		
Automobiles	12,615	1,125	$515	$172
	$20,777	$2,685	$515	$172

Rental expenses under these and similar leases aggregated $36,996 during 1977 and $32,698 during 1976.

6. Investment— Ohio Medical Indemnity, Inc.
The Association owns 100% of the outstanding common stock, 8,000 shares, of Ohio Medical Indemnity, Inc. purchased at a cost of $56,000. The Board of Directors of Ohio Medical Indemnity, Inc. (Blue Shield) is prohibited from declaring or paying any cash dividends upon such common shares of stock of the Company. In the event of liquidation of the Company, the shareholder (Ohio State Medical Association) shall be paid a sum equal to the price paid for such shares, $56,000. The Company, having an equity of $81,118,000 at December 31, 1977 and $52,358,000 at December 31, 1976, shall at liquidation distribute its remaining assets to the Association, or its successor organization, to

TREAT THE SYMPTOMS IN THE GERIATRIC PATIENT

APATHY • IRRITABILITY
FORGETFULNESS • CONFUSION



Cerebro-Nicin® CAPSULES

A GENTLE CEREBRAL STIMULANT & VASODILATOR FOR GERIATRIC PATIENTS

Each CEREBRO-NICIN capsule contains:
Pentylenetetrazole .....100 mg. • Nicotinic Acid ...100 mg.
Ascorbic Acid .....100 mg. • Thiamine HCl .....25 mg.
l-Glutamic Acid .....50 mg. • Niacinamide .....5 mg.
Riboflavin .....2 mg. • Pyridoxine HCl .....3 mg.
AVAILABLE: Bottles 100, 500, 1000
SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and abdominal cramps. The reaction is usually transient.
INDICATIONS: As a cerebral stimulant and vasodilator.
RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.
WARNING: Overdosage may cause muscle tremor and convulsions.
CONTRAINDICATIONS: Epilepsy or low convulsive threshold.
CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

Write for literature and samples . . .
BROWN THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057

be used solely and exclusively for medical research, medical education, or the development and establishment of medical care plans.

7. **Contingent Liabilities**
The Association is the defendant in a civil action brought by the Attorney General of the State of Ohio which alleges violations of federal and state antitrust laws resulting from monopolistic practices. The case is presently pending in the United States District Court, and the plaintiff seeks treble damages and divestiture of ownership in Ohio Medical Indemnity, Inc., the Association's wholly-owned subsidiary.

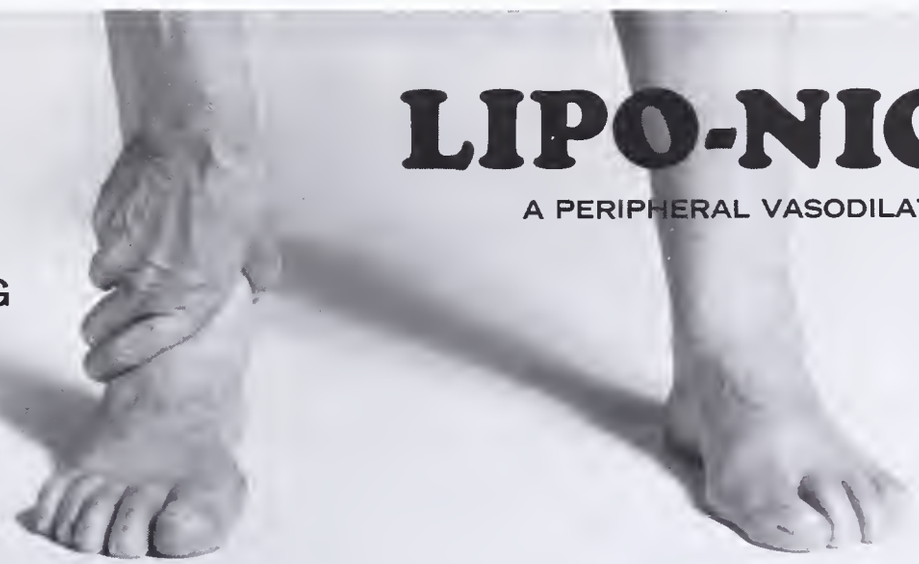
The Association is vigorously defending the action; however, it is not possible to determine the ultimate outcome of the litigation at this time.

The Association is guarantor of a $75,000 note from The Huntington National Bank to Medical Advances Institute, said note bearing interest at the rate of prime plus 2½%, 10.25% at December 31, 1977, due October 31, 1978. The note is to provide sufficient working capital for MAI to perform its obligations under a performance contract agreement. The guarantee agreement provides for, among other things, the Bank to retain a security interest in the accounts receivable and contract rights of MAI arising from the aforementioned performance contract agreement.

8. **Ohio State Medical Journal**
The income and expenses applicable to the operations of *Ohio State Medical Journal* are as follows:

	1977	1976
Income:		
Advertising (net of commissions of $19,719 in 1977 and $14,646 in 1976 and cash discounts of $1,191 in 1977 and $911 in 1976)	$ 81,546	$ 59,200
Subscriptions received from non-members	1,168	3,409
Other	551	
Membership subscriptions, allocated at $6.25 for 1977 and $5.75 for 1976, per dues-paying member (included in membership dues income on the Statement of Operations and Net Worth)	65,000	57,750
	148,265	120,359
Expenses:		
Salaries, pension costs, payroll taxes and other employee benefits	64,597	54,804
Printing, postage, stationery, supplies, illustrations, engravings, and consulting services	117,322	100,593
Building expenses, depreciation and other	16,034	14,294
	197,953	169,691
Excess of expenses over income, *Ohio State Medical Journal*	$ 49,688	$ 49,332

(Audit continued on next page)



COLD FEET
LEG CRAMPS
TINNITUS
DISCOMFORT ON STANDING

LIPO-NICIN
A PERIPHERAL VASODILATOR

IMMEDIATE or GRADUAL
nicotinic acid therapy

IMMEDIATE RELEASE

LIPO-NICIN/100 mg.
Each blue tablet contains:
Nicotinic Acid .....100 mg.
Niacinamide ..... 75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .. 25 mg.
Riboflavin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6).. 10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500, 1000.

LIPO-NICIN/250 mg.
Each yellow tablet contains:
Nicotinic Acid .....250 mg.
Niacinamide ..... 75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .. 25 mg.
Riboflavin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6).. 10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500, 1000.

GRADUAL RELEASE

LIPO-NICIN/300 mg.
Each time-release capsule contains:
Nicotinic Acid .....300 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (H-1) .. 25 mg.
Riboflavin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6).. 10 mg.
In a special base of prolonged therapeutic effect.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient. **Side Effects:** Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur. **Contraindications:** Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

BROWN THE BROWN PHARMACEUTICAL CO., INC. 2500 West Sixth Street, Los Angeles, California 90057
Write for Literature and Samples
REFER TO PDR

9. **Investment— Physicians Insurance Company of Ohio**
The Association owns 100% of the Class B common stock of Physicians Insurance Company of Ohio (PICO). PICO has two classes of common stock, Class A and Class B. Each Class of stock has equal rights on a per share basis to participate in dividends and other types of distributions, whether from earnings or in the nature of dividends. Each Class A share is entitled to one vote and each Class B share is entitled to 100 votes.

   By virtue of its ownership of 100% of the Class B shares (100 shares), the Association is entitled to 10,000 votes. At December 31, 1976, 3,000 shares of Class A were subscribed and paid for, so that effectively the Association had voting control over PICO. As of December 31, 1977, the Class A shareholders owned 7,648 shares of such stock. Accordingly at December 31, 1977, the Association was entitled to exercise 56.66% of the voting power of PICO. When the total authorized Class A shares (12,000) have been sold, the Class A shareholders will have 55% of the voting control over PICO.

   Physicians Insurance Company of Ohio had a total stockholders' equity of $7,304,836 at December 31, 1977 and $2,814,177 at December 31, 1976. The Association's equity in PICO totaled $99,036 at December 31, 1977 and $90,780 at December 31, 1976.

10. **Insurance Holding Company System**
The insurance holding company system presently consists of three affiliated persons, Ohio State Medical Association (OSMA), Physicians Insurance Company of Ohio (PICO), and Ohio Medical Indemnity, Inc. (OMI).

    OSMA owns PICO by virtue of its ownership of 100 shares of Class B common stock of PICO, comprising 100% of such authorized and outstanding shares of stock.

    OSMA owns OMI by virtue of its ownership of 100% of the issued and outstanding shares of common stock of OMI.

    There exists no relationship or affiliation between PICO and OMI, except that each is owned by OSMA.

11. **Malpractice Research Fund**
In April 1976 the Council of OSMA asked its membership to voluntarily contribute a minimum of $100 to the OSMA Malpractice Research Fund. The membership solicitation for research funds was to finance research projects in connection with the OSMA task force on Professional Liability projects, including:
    - Court Docket Survey— liability statistics
    - Counterclaim Research— legal mechanisms
    - Captive Malpractice Insurance Company— feasibility
    - Actuarial Analysis— rates of insurance statistics

    The income and expenses resulting from the membership solicitation and the task force activities on the above projects are reflected in the accompanying financial statements.

12. **Exemption— Federal Taxes on Income**
The Ohio State Medical Association is exempt from federal taxes on income under Section 501(c)(6) of the Internal Revenue Code.

13. **Physicians Insurance Company of Ohio (PICO), Investment— Current Asset (temporary investment)**
On December 15, 1976, the Association borrowed $1,500,000 under an 8¼%, 60-day note payable to a bank for the purpose of subscribing and payment for 1,500 shares of PICO Class A common stock. This action was taken in connection with a secondary offering of common shares of stock, and to enable PICO's obtaining its Certificate of Authority from the Department of Insurance of the State of Ohio on December 27, 1976. At December 31, 1976, 453 shares remained unsold under such secondary offering, and the balance of note payable amounted to $453,000. The 1,500 shares of Class A common stock and 100 shares of Class B common stock was collateralized under this note payable. The note payable to the bank was paid in full on January 11, 1977.

14. **Purchase Commitment**
The Association executed a purchase contract dated December 21, 1977 relating to the 620 South High Street property to be purchased for $80,000. ☆☆☆

Librax®

Each capsule contains 5 mg
chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

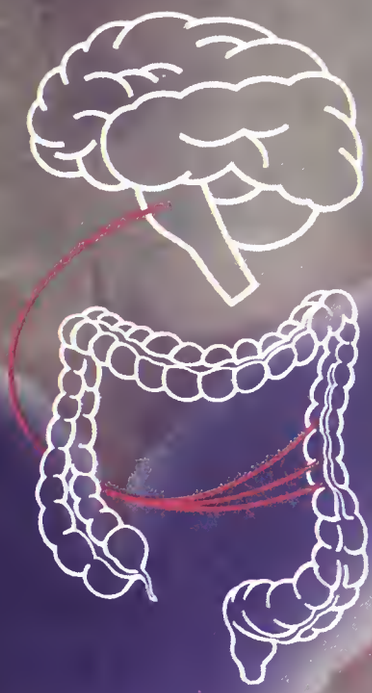
As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

ROCHE

Roche Products Inc.
Manati, Puerto Rico 00701



In treating irritable bowel syndrome*

Enhance your therapeutic expectations with

Librax®

Each capsule contains
5 mg chlordiazepoxide HCl
and 2.5 mg clidinium Br.

antianxiety/antispasmodic/antimotility

Librax is unique among G.I. medications in providing the specific antianxiety action of LIBRIUM® (chlordiazepoxide HCl) as well as the potent antispasmodic and antimotility actions of QUARZAN® (clidinium Br) for adjunctive therapy of irritable bowel syndrome.

ROCHE

*Librax has been evaluated as possibly effective for this indication.
Please see brief summary of prescribing information on preceding page.

THE OHIO STATE Medical Association Obituaries

FRANCIS W. DAVIS, M.D., Winter Park Florida; The Ohio State University College of Medicine; age 81; died July 21.

NICHOLAS GIANNESTRAS, M.D., Cincinnati; Tufts University School of Medicine, Boston, 1933; age 69; died July 6; member OSMA and AMA.

CHARLES T. GRATTIDGE, M.D., Laurelville: University of Iowa College of Medicine, Iowa City, 1921; age 82; died July 22.

FRANCIS W. LOGAN, M.D., Winter Park, Florida; University of Illinois College of Medicine, Chicago, 1928; age 74; died 1973.

CONSTANTINE MOURAT, M.D., Akron; Jefferson Medical College of Philadelphia, 1949; age 56; died July 5; member OSMA and AMA.

EDWARD B. PEDLOW, M.D., Lima; Jefferson Medical College of Philadelphia, 1923; age 83; died May 11; member OSMA and AMA.

LOUIS HENRY RICE, M.D., Cleveland; Milwaukee Medical College, 1942; age 76; died July; member OSMA and AMA.

LEWIS B. STEPHAN, M.D., Altoona, Florida; The Ohio State University College of Medicine, 1929; age 76; died July 13; member OSMA and AMA.

LINCOLN A. STEVENS, M.D., Russia, Ohio; Loma Linda University School of Medicine, Loma Linda-Los Angeles, 1968; age 49; died June 30; member OSMA.

RICHARD J. WHERRY, M.D., Bowling Green; Bowman Gray School of Medicine of Wake Forest College, Winston-Salem, 1965; age 40; died July 3; member OSMA and AMA.

REGIONAL INFECTIOUS DISEASE SYMPOSIUM

SEXUALLY TRANSMITTED DISEASES

Saturday, October 21, 1978 — 8:30 a.m. - 3:30 p.m.

Approved for Six Category I Credits

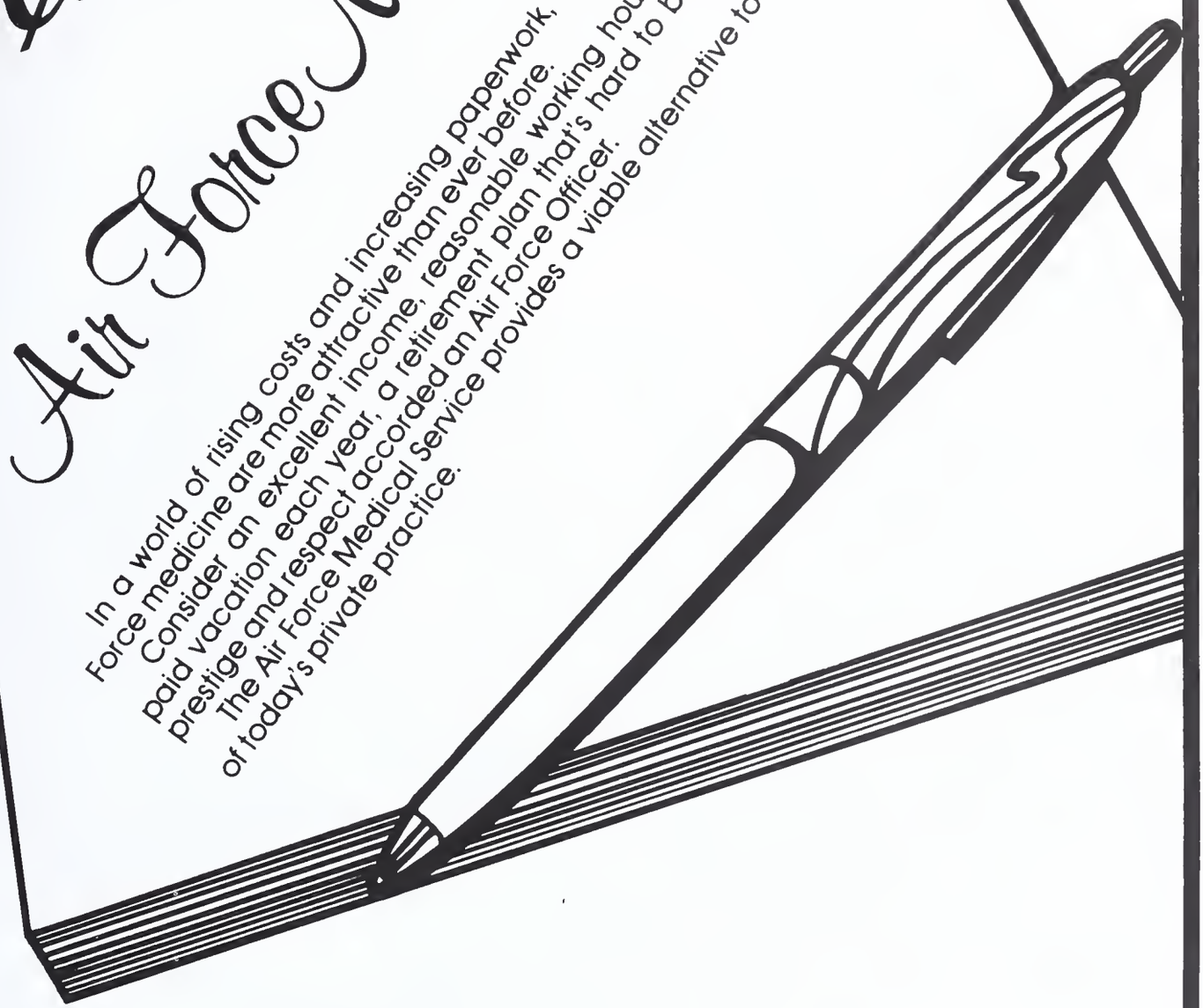
King K. Holmes, M.D., University of Washington
Lawrence R. Crane, M.D., Wayne State University
Thomas A. Chapel, M.D., Wayne State University

For further information, contact
Continuing Medical Education

HURLEY
MEDICAL CENTER

Sixth Avenue and Begole Street, Flint, Michigan 48502
(313) 766-0142

Rx: Air Force Medicine



In a world of rising costs and increasing paperwork, the benefits of Air Force medicine are more attractive than ever before. Consider an excellent income, reasonable working hours, 30 days of paid vacation each year, a retirement plan that's hard to beat, and the prestige and respect accorded an Air Force Officer. The Air Force Medical service provides a viable alternative to the rigors of today's private practice.

USAF MEDICAL RECRUITING

Bldg. 1, Area C
Wright-Patterson AFB
Ohio 45433
Phone: 513/257-7442

16101 Snow Rd.
Suite 300
Cleveland, Ohio 44142
Phone: 216/522-4325

Air Force. A great way of life.

ANCEF®

brand of sterile

CEFAZOLIN SODIUM

GETS TO THE SITE



OF SERIOUS RESPIRATORY INFECTIONS

'Ancef' Penetrates Pleural Fluid

"...levels of cefazolin in pleural fluid...generally exceeded the median MICs of all organisms commonly associated with respiratory tract infections, with the exception of a small number of isolates of Klebsiella and H. influenzae.

—Cole, D.R., et al.: Antimicrob. Ag. Chemother. 11(6):1033-1035 (June) 1977.

Tissue penetration is essential to therapeutic efficacy; however, specific tissue levels have not been directly correlated with specific therapeutic results.

Before prescribing, see complete prescribing information in SK&F literature or PDR. The following is a brief summary.

Indications: Ancef® (sterile cefazolin sodium, SK&F) is indicated in the treatment of the following serious infections due to susceptible organisms:

Respiratory tract infections due to Streptococcus pneumoniae (formerly D. pneumoniae), Klebsiella species, Hemophilus influenzae, Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), and group A beta-hemolytic streptococci.

Injectable benzathine penicillin is considered to be the drug of choice in treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. 'Ancef' is effective in the eradication of streptococci from the nasopharynx; however, data establishing the efficacy of 'Ancef' in the subsequent prevention of rheumatic fever are not available at present.

Urinary tract infections due to Escherichia coli, Proteus mirabilis, Klebsiella species, and some strains of enterobacter and enterococci.

Skin structure infections due to Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), group A beta-hemolytic streptococci and other strains of streptococci.

Biliary tract infections due to Escherichia coli, various strains of streptococci, Proteus mirabilis, Klebsiella species and Staphylococcus aureus.

Bone and joint infections due to Staphylococcus aureus.

Genital infections (i.e., prostatitis, epididymitis) due to Escherichia coli, Proteus mirabilis, Klebsiella species, and some strains of enterococci.

Septicemia due to Streptococcus pneumoniae (formerly D. pneumoniae), Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), Proteus mirabilis, Escherichia coli, and Klebsiella species.

Endocarditis due to Staphylococcus aureus (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci.

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to 'Ancef'.

Contraindications: ANCEF (STERILE CEFAZOLIN SODIUM, SK&F) IS CONTRAINDICATED IN PATIENTS WITH KNOWN ALLERGY TO THE CEPHALOSPORIN GROUP OF ANTIBIOTICS.

Warnings: BEFORE CEFAZOLIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY IN PENICILLIN-SENSITIVE PATIENTS.

SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Any patient who has demonstrated some form of allergy, particularly to drugs, should receive antibiotics cautiously. No exception should be made with regard to 'Ancef'.

Usage in Pregnancy: Safety of this product for use during pregnancy has not been established.

Usage in Infants: Safety for use in prematures and infants under 1 month of age has not been established.

Precautions: Prolonged use of 'Ancef' may result in the overgrowth of nonsusceptible organisms. Careful clinical observation of the patient is essential.

When 'Ancef' is administered to patients with low urinary output because of impaired renal function, lower daily dosage is required (see dosage instructions). A false positive reaction for glucose in the urine of patients on 'Ancef' has occurred with Clinitest® tablets solution.

Adverse Reactions: The following reactions have been reported: **Hypersensitivity:** Drug fever, skin rash, vulvar pruritus, and eosinophilia have occurred. **Blood:** Neutropenia, leukopenia, thrombocythemia and positive direct and indirect Coombs tests have occurred. **Hepatic and Renal:** Transient rise in SGOT, SGPT, BUN and alkaline phosphatase levels has been observed without clinical evidence of renal or hepatic impairment. **Gastrointestinal:** Nausea, anorexia, vomiting, diarrhea, oral candidiasis (oral thrush) have been reported. **Other:** Pain at site of injection after intramuscular administration has occurred, some with induration. Phlebitis at site of injection has been noted. Other reactions have included genital and anal pruritus, genital moniliasis, and vaginitis.

How Supplied: Ancef® (sterile cefazolin sodium, SK&F)—supplied in vials equivalent to 250 mg., 500 mg., or 1 gram of cefazolin; in "Piggyback" Vials for intravenous admixture equivalent to 500 mg or 1 gram of cefazolin; and in Pharmacy Bulk Vials equivalent to 5 grams or 10 grams of cefazolin.

ANCEF® IV IM

brand of sterile

CEFAZOLIN SODIUM

(LYOPHILIZED)

Injection: 250 mg., 500 mg. and 1 gram vials

Smith Kline & French Laboratories
Philadelphia, Pa.

SK&F
a SmithKline company

Practice Productivity Inc.

Cosponsored by the

Ohio State Medical Association

ONE DAY WORKSHOP

BUSINESS ESSENTIALS FOR A MEDICAL OFFICE

FOR YOUR MEDICAL OFFICE ASSISTANTS

8:45 a.m. to 5:00 p.m.

Oct. 17, 1978	Toledo	Sheraton-Westgate Inn
Oct. 18, 1978	Cleveland	Marriott Inn - Airport
Oct. 19, 1978	Akron	Tangier Restaurant
Oct. 24, 1978	Columbus	Marriott Inn
Oct. 25, 1978	Dayton	Imperial Crown Dayton
Oct. 26, 1978	Cincinnati	Marriott Inn
Oct. 31, 1978	Lima	Ramada Inn
Nov. 1, 1978	Canton	Sheraton Belden Inn
Nov. 2, 1978	Youngstown	Howard Johnson's Motor Lodge

OFFICE MANAGERS
RECEPTIONISTS
MEDICAL SECRETARIES
BOOKKEEPERS
INSURANCE CLERKS
NURSES

This program has been approved for Continuing Education Units by AAMA

TOPICS: Telephone Management, Appointment Scheduling, Medical Records, Personnel, Billing Systems and Collection, Insurance Claim Processing.

Practice Productivity Inc. is a national management consulting firm located in Atlanta whose only clients are physicians engaged in the private practice of medicine. Practice Productivity offers educational and motivational workshops in sound business concepts to physicians, medical office managers, and medical assistants. Practice Productivity also provides nation-wide individual consulting to physicians at their private practice.

For Further information, contact:
Duane M. Johnson, PhD, Executive Vice-President, Practice Productivity, Inc.

Registration Form

Name	Position	City Will Attend	Date Will Attend
1.			
2.			
3.			

Name of Practice: _____

Specialty: _____ Telephone: (_____) _____

Address: _____

City: _____ State: _____ Zip: _____

Full tuition fee of $ _____ is enclosed at $75 per registrant. Tuition includes course materials and luncheon and MUST ACCOMPANY THIS FORM. (There is a $10 handling fee deducted on all refunds for cancellations received at least one week in advance of course; no refund thereafter.)

Practice Productivity Inc.

2000 Clearview Avenue, Atlanta, Georgia 30340, Telephone (404) 455-7344 or Toll Free 800-241-6228

The Ohio Medical Association Clinical and Scientific

Thyroxine-Binding Globulin Deficiency: Innocent Cause of Low Serum Thyroxine (T_4) Levels

Bonnie L. Typlin, M.D.
Thomas E. Shaffer, M.D.

With increased awareness of primary neonatal hypothyroidism through screening, the familial condition of thyroxine-binding globulin (TBG) deficiency must be considered in evaluating neonates with low serum thyroxine (T_4) levels. Clinical data are presented for an adolescent with low T_4 who was erroneously treated for hypothyroidism. As is the hallmark of TBG deficiency, she had a low T_4, normal thyroid-stimulating hormone (TSH), and an elevated resin triiodothyronine uptake (RT_3U). This congenital problem is felt to be X-linked recessive in some families and autosomal dominant in others. No treatment is needed for TBG deficiency, and patients are clinically euthyroid. The incidence of neonatal primary hypothyroidism is 1:5,760, while the incidence of TBG deficiency is 1:14,000. Therefore, careful evaluation of all low T_4s must be made in order to rule out TBG deficiency.

A PILOT PROGRAM TO SCREEN newborn infants for primary neonatal hypothyroidism was begun in Cuyahoga County, Ohio, in September 1977. Similar programs have been initiated in Stark, Summit, and Lucas counties in 1978. A familial condition, which might be erroneously diagnosed as congenital hypothyroidism when the screening procedure demonstrates a low blood level for thyroxine, is very important to correctly evaluate the screening test results.

This article describes a family in which deficiency of thyroxine-binding globulin (TBG) exists as a hereditary condition. The index case, a 13-year-old girl, was diagnosed originally as having hypothyroidism. Her subsequent medical history illustrates the importance of following recommended diagnostic procedures in the proposed neonatal screening program.

TBG deficiency is a hereditary defect in the primary carrier protein for thyroxine (T_4) and triiodothyronine (T_3), and 64% of circulating thyroxine is bound to this globulin. Prealbumin and albumin are other serum proteins involved in transport of thyroxine. Individuals who have TBG deficiency are clinically euthyroid, but certain biochemical evidence suggesting hypothyroidism is present: decreased T_4 and decreased T_3 radioimmunoassay (RIA) test. However, other tests for thyroid function, the thyroid stimulating hormone level (TSH) and free thyroxine (FT_4) are always normal. Furthermore, T_3 uptake (RT_3U) is elevated in this condition.

A girl, aged 13 years and ten months, complained of persistent headaches, dizziness, and that her hair was "falling out." The problem of headache was of long duration, and subsequent evaluation indicated that she had school phobia. It was decided that the headaches, having no physical basis, were used to support nonattendance in

Dr. Typlin, Chicago, currently Instructor in Pediatrics, Michael Reese Medical Center, was a Fellow in Ambulatory Pediatrics, Children's Hospital, Columbus, when this paper was prepared.

Dr. Shaffer, Columbus, Clinical Director, Teenage Clinic, Children's Hospital; and Emeritus Professor of Pediatrics, The Ohio State University College of Medicine.

Reprint requests to Department of Pediatrics, Michael Reese Medical Center, 29th St. & Ellis Ave., Chicago, Ill. 60616 (Dr. Typlin)

Submitted February 21, 1978.

school. The dizziness was found to be due to hyperventilation.

The patient weighed 40.4 kg (89 lb) which is 12th percentile for her age. She was 143.8 cm (4 ft 11½ in) tall, tenth percentile for age. Menarche had occurred at age 12 years; menstrual cycles were said to have occurred regularly every month since that event. A complete physical examination revealed no abnormalities except small size. Routine laboratory tests showed no abnormalities of the blood and urinary systems. There were no clinical signs of hypothyroidism.

Because of the history of loss of hair during the previous three years, a total thyroxine (T_4) test was done and the T_4 level was found to be low. (See the Table.) Following confirmation of decreased T_4 level, thyroid therapy, 60 mg daily, was instituted without further laboratory investigation. During a period of four months, a gradual increase of desiccated thyroid to 180 mg daily produced no appreciable elevation of the T_4 level; the patient remained clinically euthyroid with no symptoms of toxic reaction to the medication. During this period, the resin T_3 uptake test (RT_3U) was found to be elevated although the T_4 was repeatedly shown to be diminished. *These are paradoxical findings which are the hallmark for suspicion of the diagnosis of TBG deficiency.*

After many months of unsuccessful attempts to elevate the T_4 level by thyroid medication, the patient's thyroid function was reevaluated following a four-month period in which thyroid medication was withheld. The reevaluation disclosed a subnormal level of TBG and a normal level of free thyroxine (FT_4), in addition to the previously demonstrated low T_4 level. The diagnosis of TBG deficiency was evident and, in view of clinical euthyroidism and normal FT_4 in the serum, medication for hypothyroidism was discontinued permanently. During the 22-month period of study, the patient attained a height of 155.6 cm (5 ft 1¼ in), approximately at the 20th percentile for her age.

Following the diagnosis of TBG deficiency in this individual, five siblings and the patient's mother were evaluated. The mother and one half-sister were found to have TBG deficiency. As all other relatives lived in distant parts of the United States, further investigations to obtain the incidence of TBG deficiency in this family could not be carried out.

Results of Thyroid Function Tests

Test	Result	Normal Range
T_4 (initial)	3.3 μg/100 ml	4.4 to 12.2 μg/100 ml
T_4 (under adequate treatment)	3.9 μg/100 ml	4.4 to 12.2 μg/100 ml
RT_3U	41.6%	25 to 35%
TBG	1-8 μg	2.5 to 4.8 μg
Thyroid antibodies	absent	absent
TSH	<0.5 μU/ml	up to 10 μU/ml
FT_4	0.9 ng/100 ml serum	1.5 to 4.0 ng/100 ml serum

Discussion

TBG deficiency was first described in 1959 by Tanaka and Starr,[1] and by Beierwaltes and Robbins.[2] Subsequently, other investigators characterized TBG deficiency as a hereditary defect, limiting the transport of T_4 and T_3 by carrier proteins in the blood.[3-9] Low serum levels of T_4 and T_3 are found but there are no signs of abnormal thyroid function, and thyroid stimulating hormone (TSH) levels are normal. The condition is a familial trait; the most likely mode of transmission appears to be X-linked although some kindred appear to represent autosomal dominant transmission.

The incidence of TBG deficiency is low in the population, but it is a significant entity when compared with the incidence of neonatal hypothyroidism with which it might be confused. A summary of results of preliminary screening programs for congenital hypothyroidism among neonates reveals an incidence of congenital hypothyroidism of 1 per 5,760 births,[10] while the occurrence of TBG deficiency was 1 per 14,000 births.[11] Thus, the chances for encountering TBG deficiency and erroneously diagnosing hypothyroidism, solely on the basis of a low T_4 level, create a significant problem.

The fact sheet for hypothyroid screening proposed by the Ohio Department of Health recommends: "If the T_4 level is questionable, the test is to be repeated and followed by a TSH test."[12] These tests will be done, upon request, in the Laboratory of the Ohio Department of Health. If the valid diagnosis is hypothyroidism, the T_4 level will be consistently below normal and the TSH test will be above normal levels. TBG deficiency, on the other hand, would be *suspected* when the TSH test result is normal and the T_4 level is decreased. Differentiation between primary hypothyroidism and TBG deficiency would be clarified by determination of the RT_3U level. Low T_4, elevated TSH, and a low RT_3U *confirm* the diagnosis of neonatal hypothyroidism, while low T_4, normal TSH, and elevated RT_3U indicate a diagnosis of TBG deficiency. As patients with TBG deficiency are essentially healthy, the importance of making such differentiation, to avoid unnecessary medication and medical care, is obvious.

Summary

The proposed program for screening newborns for primary neonatal hypothyroidism, sponsored by the Ohio Department of Health, is a forward step in the early detection of a remediable cause of mental retardation. Special precautions must be taken to clarify the significance of a low T_4 level in the neonate's blood because a familial condition, thyroxine-binding globulin (TBG) deficiency, may cause confusion unless further tests to differentiate the two conditions are carried out. As TBG deficiency has no clinical significance for thyroid function and it is not a cause of mental retardation, the identi-

fication of the defect and differentiation from neonatal hypothyroidism are of utmost importance.

Reference

1. Tanaka S, Starr P: A euthyroid man without thyroxine-binding globulin. *J Clin Endocrinol Metab* 19:484-487, 1959.

2. Beierwaltes WH, Robbins J: Familial increase in the thyroxine-binding sites in serum alpha globulin. *J Clin Invest* 38:1683-1688, 1959.

3. Nicoloff JT, Dowling JT, Patton DD: Inheritance of decreased thyroxine-binding by the thyroxine-binding globulin. *J Clin Endocrinol Metab* 24:294-298, 1964.

4. Nikolai TF, Seal US: X-chromosome linked familial decrease in thyroxine-binding globulin activity. *J Clin Endocrinol Metab* 26:835-841, 1966.

5. Marshall JS, Levy RP, Steinberg AG: Human thyroxine-binding globulin deficiency. *N Eng J Med* 274:1469-1473, 1966.

6. Nikolai TF, Seal US: X-chromosome linked inheritance of thyroxine-binding globulin deficiency. *J Clin Endocrinol Metab* 27:1515-1520, 1967.

7. Kraemer E, Wiswell JG: Familial thyroxine-binding globulin deficiency. *Metabolism* 17:260-262, 1968.

8. Moloshok RE, Hsu LY, Seal US, et al: Partial thyroxine-binding globulin deficiency in a family. *Pediatrics* 44:518-525, 1969.

9. Roberts RC, Nikolai TF, Lohrenz FN: A TBG-deficient family with a male exhibiting decreased but not zero TBG levels. *J Clin Endocrinol Metab* 30:144-146, 1970.

10. Fisher DA, Burrow GN, Dussault JH, et al: Recommendations for screening programs for congenital hypothyroidism. Report of a committee of the American Thyroid Association. *Am J Med* 61:932-934, 1976.

11. Dussault JH, Letarte J, Guyda H, et al: Serum thyroid hormone and TSH concentrations in newborn infants with congenital absence of thyroxine-binding globulin. *J Pediatr* 90:264-265, 1977.

12. Pilot Project Announcement from John Ackerman, M.D., Ohio Department of Health, Columbus, July 1977. ☆☆☆

IMMKE CIRCLE LEASING INC

Endorsed Leasing Company
Of The Ohio State Medical Association

Order now for early delivery on all 1979 models

We lease all foreign and domestic makes and models
including Mercedes, Jaguar, Porsche, etc.

Many people think of leasing as just automobiles.
We do that too, but, in addition, we want to lease you any professional equipment.

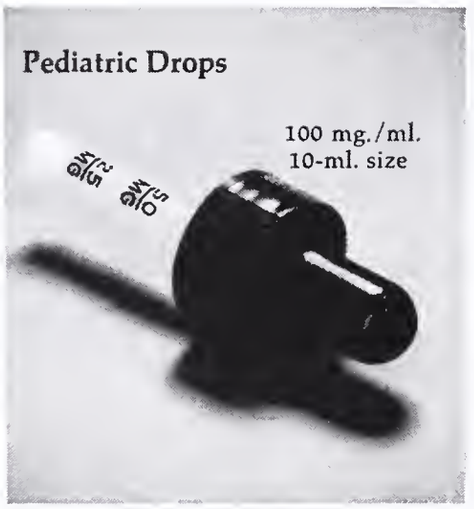
Immke Circle Leasing, Inc.
32 South Fifth Street
Columbus, Ohio 43215

Telephone 614-228-1701 or Toll Free 1-800-282-0256

easy to take







Keflex®
cephalexin

Lilly

500738

Additional information available to the profession on request.
Eli Lilly and Company
Indianapolis, Indiana 46206

A Congenital Anomaly of the Ribs

Emil Gutman, M.D.

Many anomalies have been well documented and long recognized. An anomaly involving the ribs in which the most lateral aspect is in medial position in respect to the area in the adjacent ribs was noted in 13.2% of 1,000 consecutive, normal chest roentgenograms. We are not aware of previous reports of this anomaly. Involvement was found unilaterally and bilaterally from the fourth through the eighth rib and in a range from one to five ribs. This entity should be included among the other known rib anomalies.

A WIDE VARIETY OF congenital anomalies have long been known and repeatedly reported involving areas from the toes (supernumerary toes) to the skull (familial idiopathic acro-osteolysis).[1]

Some so-called congenital anomalies are referred to by some radiologists as normal variants or developmental variants and are particularly susceptible to notice by those confronted with voluminous routine-type examinations. Thus, Dr. Benjamin Felson reported on normal and anomalous chest findings, first in a series of 18,000 normal chest roentgenograms, and subsequently on over 30,000 of such examinations.[2,3]

It has been noted that developmental rib abnormalities are not infrequent or clinically significant, but they should be noted and recognized as such.[4]

Perhaps the most similar to the findings in this report is a case with bilateral hypoplasia of the upper four ribs shown by Dr. John Caffey.[5] Reference to the entity herein discussed could not be located in current literature or in more extensive tests dealing with skeletal radiology.[4,5,6] This anomaly may be of significance in lung scans and in some types of trauma, and it should be included in any complete account of rib anomalies.

If a straight line were drawn tangentially at the lateral aspects of the ribs on a routine, 6-ft posteroanterior view of the chest, the lateral excursion of one or more ribs sometimes will be found to fall inside this line. We noted this finding in 132, or 13.2%, of 1,000 consecutive cases.

The condition was unilateral in 86 cases (8.6%) in which, with one exception, only the right side was involved. Most frequently, the right sixth or seventh, and rarely the fourth or fifth single rib, was involved. (See Figures 1 and 2.) Multiple ribs unilaterally again was noted most in the sixth and seventh ribs (Fig. 3). As noted with unilateral involvement, no ribs above the



FIG. 1 (left). Excursion of right fifth rib medial to that of fourth and sixth. FIG. 2 (center). Lateral borders right sixth and seventh ribs to that of fifth and eighth. FIG. 3 (right). Involvement of fourth through eighth rib on right, fifth through eighth on left.

fourth or below the eighth were involved and the single unilateral rib on the left was the sixth rib.

Of the 86 unilateral cases, 41 were single rib involvement, especially in the seventh (21 cases) and sixth (13 cases) ribs. Two ribs were unilaterally involved in 30 cases of which the sixth and seventh accounted for 18, the seventh and eighth for ten, and the fifth and sixth for two cases. Triple ribs (right side only) were seen in 13 cases of which the sixth, seventh, and eighth were noted in eight cases, and the fifth, sixth, and seventh in five cases. Two cases had involvement of the right fifth through eighth ribs.

With bilateral involvement (46 cases or 4.6%), most were those with a single rib on the left and multiple ribs on the right. Again the range was from the fourth through the eighth with the most from the fifth through the seventh. The greatest number was seen in a single case with five ribs (four through eight) on the right and four (five through eight) on the left.

From the Radiology Service, Veterans Administration Center, Dayton, Ohio.

Dr. Gutman, Dayton Radiology Service, Veterans Administration Center, Dayton; and Clinical Associate Professor of Radiology, Wright State University School of Medicine.

Reprint requests to Veterans Administration Center, 4100 West Third St., Dayton, Ohio 45428 (Dr. Gutman).

Submitted February 3, 1978.

Summary

A congenital anomaly has been noted in 13.2% of 1,000 routine chest roentgenograms. The lateral excursion of the rib reaches a point medial to that of the superior and inferior ribs. Involvement has been noted in single as well as multiple ribs, and bilaterally as well as unilaterally. This should be considered in lung scans as well as in some types of trauma.

References

1. Murray RO, Jacobson HG: *The Radiology of Skeletal Disorders: Exercises in Diagnosis* (ed 2). Edinburgh, London, & New York, Churchill Livingstone, 1977, vol 1, p 11.
2. Felson B: *Chest Roentgenology*. Philadelphia, W B Saunders, 1973, pp 494-495.
3. Felson B: *Fundamentals of Chest Roentgenology*. Philadelphia, W B Saunders, 1960, p 265.
4. Paul LW, Juhl JH: *The Essentials of Roentgen Interpretation* (ed 3). Hagerstown NY & San Francisco, Harper & Row, 1972, pp 771-772.
5. Caffey J: *Pediatric X-ray Diagnosis* (ed 6). Chicago, Yearbook Publishers, 1973, p 280.
6. Kohler A, Zimmer EA: *Borderlands of the Normal and Early Pathologic in Skeletal Roentgenology* (ed 3). New York & London, Grune & Stratton, 1968, pp 174-184. ☆☆

When was the last time your practice gave you a good night's sleep?

We're not talking about sleep that comes from sheer exhaustion.

We're talking about the kind of sleep that comes from knowing you practiced medicine today the way it was meant to be practiced. Of giving your patients the very best in medical care. With no compromises.

And a sleep that comes from knowing you won't be spending all of tomorrow morning filling out Medicare insurance forms, or attending to a myriad of other time-consuming, nonmedical duties.

But there is a practice that offers an alternative to the kind of medicine you're now practicing. A practice in the U.S. Navy.

The Navy physician.

As a Navy physician, we feel your time is too valuable to spend on administrative details. So they're kept to a minimum. Instead, a highly trained staff of professionals attends to the paperwork. The end result is that almost all your time can be spent practicing medicine.

A challenging practice.

You'll be given a practice that's as varied and challenging as any you'll find in a civilian setting. You'll be treating active duty personnel as well as their dependents and retired personnel.

Insurance.

A recent Act of Congress now makes it unnecessary for federally employed physicians to carry high cost insurance. As a practicing Navy physician, you will receive professional liability protection under the Federal Tort Claims Act.

Other benefits.

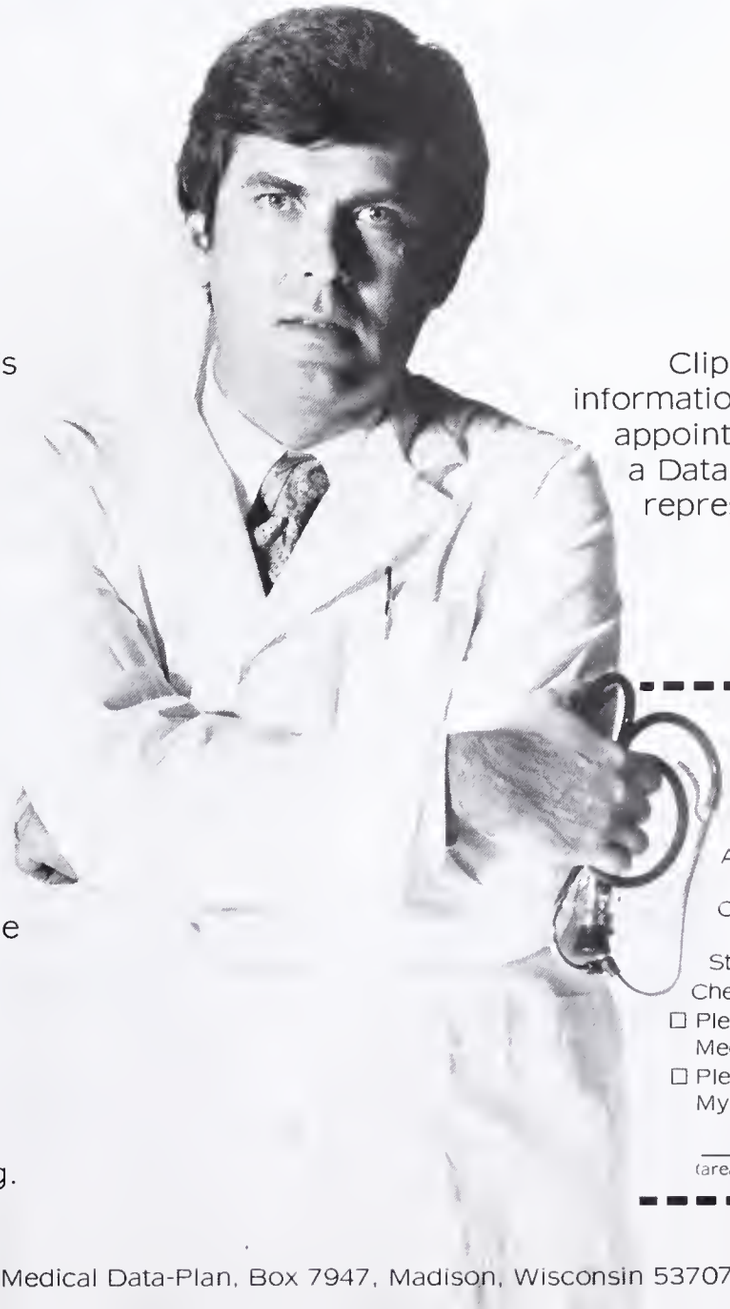
There are plenty of other great benefits that go with being a Navy physician. Good pay— $30,000 to start, more, depending on your experience. A family life with time for your family. Associating with other highly motivated physicians. Even 30 days' paid vacation a year.

But the best way to get all the facts is to mail the coupon, or call the Medical Recruiter, toll-free, 1-800-282-1288.

Be the doctor you want to be. In the Navy.

Medical Data-Plan®

We're not offering you just a computerized billing system. We're offering you a way to plan the future of your practice.



Medical Data-Plan is a computerized system for getting bills out, processing insurance forms, speeding up cash flow and improving collections.

It also gives you the information you need to plan the future of your practice . . . 3 years, 5 years, 10 years from now.

Based on a steady flow of accurate, timely computer reports, your business manager can make sound recommendations on personnel, equipment, materials, facilities and more. Medical Data-Plan can show you what your practice has been doing—and what it should be doing.

Clip this coupon to receive information or to arrange an appointment with a Data-Plan representative.

Data-Plan

OM

Medical Data-Plan
Box 7947, Madison, Wisconsin 53707

Name _____

Address _____

City _____

State _____ Zip _____

Check one or both boxes below:

☐ Please mail me more information about Medical Data-Plan.

☐ Please have a representative contact me. My phone number is:

_____
(area code) (number)

Medical Data-Plan, Box 7947, Madison, Wisconsin 53707



If Our Area Manager Isn't In Maybe Our Secretary Can Help

Our Blue Shield professional relations managers are busy people, constantly out calling on doctors and their office staffs. Which means that if you phone, the area manager may not be in at that moment.

However, expert help may still be available. The area office secretaries are trained and capable in providing assistance with the more common and frequent kinds of matters.

They can check on the status or disposition of claims, answer questions about whether a certain service is payable under a specific contract or find out if the patient is a currently enrolled Blue Shield subscriber.

We take our service seriously...all of us.

Blue Shield

Ohio Medical Indemnity, Inc.

6740 North High Street, Worthington, Ohio 43085

Clinical Observations Following Papaverine Therapy

Gordon B. Snider, M.D.
Shashi A. Gogate, M.D.

A description of suspected hepatotoxic reaction to papaverine hydrochloride is presented with clinical data for two patients who developed anorexia, jaundice, and fever four to five weeks after initiation of the drug therapy. After discontinuance of the drug, the patients returned to normal physiologic state.

PAPAVERINE, AN OPIUM derivative, has been widely used for relaxation of smooth muscles especially in the blood vessels. This drug has been used in patients presenting with disturbances of cerebral and coronary circulation, in addition to other clinical conditions.[1-3] Reports of hepatic toxicity have been rare in spite of its increased use in the last decade or so. We believe the following clinical observations are the first reported cases in this country of hepatotoxicity due to papaverine with development of jaundice, eosinophilia, elevation of the alkaline phosphatase and substantiated by liver biopsy.

Clinical Data

A 71-year-old woman was hospitalized with a cerebral thrombosis and a left hemiparesis following a cerebral vascular accident. She was treated at that time with physiotherapy and papaverine hydrochloride, in capsule form given every 12 hours. This medication was begun on the day of admission. Liver function studies at this time included a total bilirubin of 1.0 mg/dl, alkaline phosphatase of 8.9 IU/liter with an upper level of 9.7 IU/liter being normal. Lactic dehydrogenase (LDH) was 146 IU/liter with a normal being 97 to 193 IU/liter, serum glutamic oxaloacetic transaminase (SGOT) of 32 IU/liter with a normal of 12 to 32 IU/liter. In addition, blood urea nitrogen (BUN) was 14 mg/dl, creatinine level 0.7 mg/dl, and protein 6.5 mg/dl. (See Table.) The patient remained in the hospital for 21 days. She was discharged home on papaverine hydrochloride therapy, 150 mg every 12 hours, her condition to be followed by her family physician. She did well at home for several weeks; then she began to notice dark urine, clay-colored stools, and anorexia. On examination by her family physician, she was found to be jaundiced, and was referred to the hospital for readmission. Several days prior to admission, she had some chills and fever. She

Variations in Bilirubin, Alkaline Phosphatase, SGOT, and Serum Cholesterol in Relation to Oral Administration of Papaverine Hydrochloride

Date	Cholesterol mg/dl	Bilirubin mg/dl	Alkaline Phosphatase IU/liter	SGOT IU/liter
Patient #1				
March 8	200	1.2	8.9	32.0
April 27	210	12.0	79.0	47.0
April 29*	220	12.7	74.0	71.0
May 2	375	9.0	74.0	42.0
May 5	420	7.2	75.0	45.0
May 19	350	3.0	69.0	20.0
August 24	203	1.0	8.0	24.0
Patient #2				
November 4	250	1.1	6.5	40.0
November 25	257	1.1	6.0	34.0
December 6*	248	7.9	54.0	49.0
December 9	251	5.7	45.0	33.0
December 12	211	2.7	45.0	31.0
December 15	196	2.0	40.0	30.0
December 18	227	1.7	20.0	27.0
December 21	220	1.3	18.1	27.0

*Papaverine therapy discontinued.

Dr. Snider, Lancaster, Chairman, Coronary Care Unit Committee and Chief of Medical Education, Lancaster Fairfield County Hospital; and Director of The Ohio State University Family Oriented Primary Care Program in Lancaster.
Dr. Gogate, Lancaster, Director of Laboratories, Department of Pathology, Lancaster Fairfield County Hospital; and Assistant Clinical Professor of Pathology, The Ohio State University College of Medicine.
Submitted February 15, 1978.

was receiving no other medication at that time except for papaverine hydrochloride in a capsule form.

Physical examination on readmission revealed a well-developed, well-nourished white woman who was alert, cooperative, and able to converse without difficulty. There was no obvious residual of her previous cerebrovascular accident. Her skin was deeply icteric; there was no adenopathy; the lungs were clear to palpation and auscultation. The heart tones were normal except for an S4 sound. The liver was palpable two fingerbreadths below the right costal margin, tender, and the edge sharp. The spleen was palpable, reflexes were hypoactive on the left side, and Babinski's reflex now was negative. In laboratory studies on April 27th, urinalysis was positive for bile, and urine was dark-straw colored. The white blood cell (WBC) count was 15,000/cu mm with 32% eosinophils, 6% band forms, 51% segmented neutrophils, 5% lymphocytes, and 6% monocytes. Electrolyte and red blood cell indicies were normal. Laboratory values on admission were: glucose (fasting) blood 78 mg/dl, serum alkaline phosphatase 79 IU/liter, and LDH 93 IU/liter. Subsequent laboratory studies showed persistent elevation of serum cholesterol, alkaline phosphatase, and a gradual reduction in bilirubin and SGOT levels. The cholestrol level reached a peak of 420 mg/dl, the SGOT peaked at 71 IU/liter, and all values gradually declined to normal levels. Results of liver and spleen scan were reported as normal; rose bengal scan was reported as being normal, indicating patency of the biliary tree. A liver biopsy revealed: "Liver cells were normal in appearance except for slight increased intracellular pigment, the sinusoids were dilated and slightly congested, minimal liver cell necrosis was seen, occasional bile plug was seen in the biliary canaliculi. Portal areas showed diffuse neutrophilic cell infiltration, the predominant cell type being eosinophils. The blood vessels were unremarkable." (See Figure.)

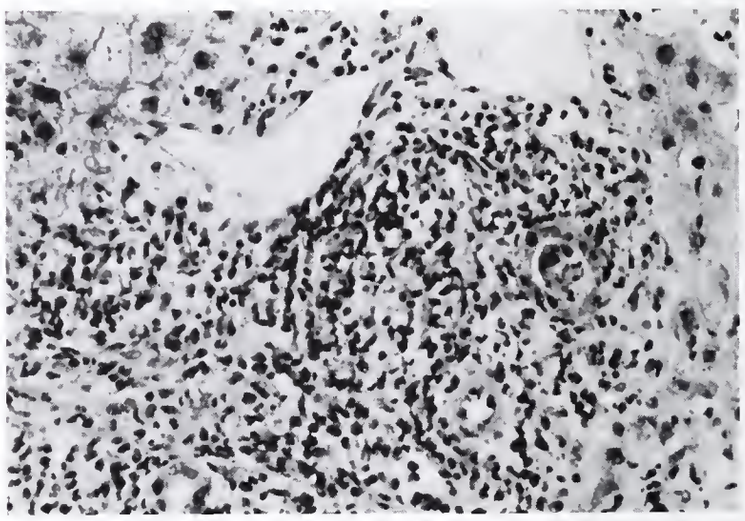
Diagnosis was acute pericholangitis, confirmed by needle biopsy of the liver. It was thought that these changes were consistent with drug-induced portal inflammation.

Hospital Course— Papaverine therapy was discontinued. Liver biopsy was performed without incident and the patient's temperature, rash, and jaundice all cleared rather dramatically after the medication was stopped. The patient's appetite improved, and she was discharged from the hospital on the 11th hospital day, markedly improved. Subsequent laboratory studies showed serum cholesterol 350 mg/dl, alkaline phosphatase 69 IU/liter, SGOT 20 IU/liter, serum glutamic pyruvic transaminase (SGPT) 27 IU/liter, and bilirubin level 3.0 mg/dl. Repeat studies four months after hospital discharge included cholesterol and alkaline phosphatase, SGOT, SGPT, and bilirubin, all within normal limits. (See Table.)

A 71-year-old hypertensive, white man was admitted with partial aphasia and hemiparesis. These symptoms cleared within 24 hours, and it was thought that they were of a transient ischemic episode. He was given four doses of papaverine hydrochloride intramuscularly in a 48-hour period. Persantine,® 25 mg, four times a day, and aspirin, 10 gr daily. He became ambulant promptly and was discharged home on Persantine,® acetylsalicylic acid, papaverine hydrochloride, and his previous antihypertensive medication, Hydropres.® He did well at home and resumed caring for his invalid wife. Approximately 20 days later, he suddenly developed right hemiparesis and aphasia and was brought to the hospital immediately. The same regimen of intramuscular papaverine was resumed. After six days, it was discontinued and papaverine hydrochloride in a capsule form was given, 150 mg every 12 hours. After 12 days on this drug therapy regimen, he was noted to be jauniced, his urine was dark colored, and tested positive for bile.

The papaverine therapy was discontinued. Results of laboratory tests on admission revealed bilirubin 1.1 mg/dl, LDH 35 IU/liter, SGOT 34 IU/liter, serum cholesterol 257 mg/dl, and alkaline phosphatase 6.5 IU/liter. On the day the papaverine was discontinued the alkaline phosphatase level had risen to 54 IU/liter, total bilirubin was 7.9 mg/dl, SGOT 49 IU/liter, and LDH 86 IU/liter. Six days later, the alkaline phosphatase was 45 IU/liter and the bilirubin had fallen to 5.1 mg/dl. SGOT was 33 IU/liter and the cholesterol was 251 mg/dl. Also on that date, a complete blood count revealed an eosinophilia of 8 eosinophils/100 cells counted whereas there was none on admission.

Hospital Course— As soon as the patient became jaundiced, it was suspected that he had a hypersensitivity reaction to some medication. Biopsy of his liver showed cholestasis and pericholangitis. The comment was: "In view of the severe cholestasis and mild liver-cell necrosis with pericholangitis, drug-sensitivity-type cholestasis should be ruled out, in addition to other causes of cholestasis. The patient's jaundice cleared rather rapidly, and all liver function studies showed normal levels after the papaverine hydrochloride therapy was discontinued. (See Table.)



Liver biopsy showed portal areas with diffuse neutrophilic cell infiltration, eosinophilic cell being predominant cell type.

Comment

Papaverine hydrochloride, an opium derivative, has been used in the treatment of coronary artery disease.[2-3] Recently, it has been used extensively for increasing cerebral blood flow. Reports of hepatotoxicity due to papaverine appeared in literature in 1969, when four cases were reported from Denmark.[4] All patients had abdominal discomfort with elevation of alkaline phosphatase and transminase levels. These findings were further substantiated by liver biopsies. Hypersensitivity reaction as the most likely mechanism of hepatotoxicity was postulated.[4-6] All patients improved clinically on withdrawal of papaverine. The same authors have since published histopathologic findings on eight patients including two patients from their original series.[7]

In other series, 30 patients were studied for hepatotoxicity due to papaverine.[8] Sixty percent of the patients in that study group reacted to the drug with abnormally high levels of alkaline phosphatase, 13% of them with high levels of SGOT and SGPT, and 20% with an increase in the eosinophil count. However, none of the 30 patients manifested jaundice, dark urine, abdominal discomfort, or nausea and vomiting.

Summary

Our patients developed a hypersensitivity reaction to papaverine hydrochloride which was verified by laboratory evidence of hepatotoxicity, eosinophilia, and liver-biopsy verification of the process. The cessation of the patients' papaverine therapy caused dramatic improvement in their clinical course. Subsequent laboratory studies indicated that hypersensitivity state no longer existed. Patients receiving this medication for its various indications should be monitored closely for evidence of hypersensitivity reaction and hepatotoxicity as was seen in the patients described herein.

Generic and Trade Names of Drugs

Dipyridamole — Persantine (Boehringer Ingleheim Ltd.)

Hydrochlorothiazide and resperine — Hydropres (Merck Sharp & Dohme)

References

1. Stern FH: Management of chronic brain syndrome secondary to cerebral arteriosclerosis, with special reference to papaverine hydrochloride. *J Am Geriatr Soc* **18**:507-512, 1970.
2. Gray W, Riseman JEF, Stearns S: Papaverine in the treatment of coronary-artery disease. *N Eng J Med* 232:389-394, 1945.
3. Elek SR, Katz LN: Some clinical uses of papaverine in heart disease. *JAMA* **120**:434-441, 1942
4. Rønnov-Jessen V, Tjernlund A: Hepatotoxicity due to treatment with papaverine. Report of four cases. *N Eng J Med* **281**:1333-1335, 1969.
5. Zimmerman HJ: Papaverine revisited as a hepatotoxin. *N Eng J Med* **281**:1364-1365, 1969.
6. Sherlock S: *Diseases of the Liver and Biliary System* (ed 5). Oxford, Blackwell Scientific Publications, 1975, pp 372-373.
7. Kiaer HW, Olsen S, Rønnov-Jessen V: Hepatotoxity of papaverine. *Arch Pathol* **98**:292-296, 1974.
8. Driemen PM: Papeverine: Hepatotoxic or not? *J Am Geriatr Soc* **21**:202-205, 1973. ☆☆☆

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

OHIO OFFICES:

CINCINNATI: Raam 700, 3333 Vine Street, (513) 751-0657, L. A. Flaherty

CLEVELAND: Suite 106, 23360 Chagrin Boulevard, Beachwood 44122, (216) 464-9950

A. C. Spath, Jr., R. A. Zimmerman

COLUMBUS: 1989 West 5th Ave., (614) 486-3939, J. E. Hansel

TOLEDO: 1011 Sandusky St., Suite H, P.O. Box 331, Perrysburg 43551, (419) 874-8080, R. E. Stallter

PICO

It's good medicine



Physicians Insurance Company of Ohio offers Ohio State Medical Association members a "total protection program."

Total protection means not only the finest professional liability insurance plan available, but also low-cost insurance coverages for your office, homes, autos and other possessions.

PICO can even insure your antique car or your golf cart.

PICO. Formed by physicians to serve physicians.

It's just plain good medicine.

Physicians Insurance Company of Ohio
6100 Channingway Boulevard
Columbus, Ohio 43227
Telephone (614) 864-3043

PICO

Evaluation of Surgical and Medical Hospitalizations in Columbus, Ohio

William T. Paul, M.D.

A prospective, subjective evaluation of 87 surgically and medically hospitalized patients returning to work at a local industrial plant in 1977 is presented. It describes the author's evaluation of the necessity for such hospitalization and treatment, based on the patient's history of complaints and the results of physical examination made when the patient returned to work. The article cites the author's experience as a referring family physician, a member of a hospital utilization committee, and an industrial plant physician.
This evaluation was motivated by the recent rash of books and articles implying that the medical profession renders unnecessary surgical and medical treatment.

I am in partnership in general and family practice with one other physician of similar credentials and experience. Our office is located in suburban Columbus. My practice consists of 150-to-200 patient visits spanning a period of over 20 years. Approximately 10% of these visits per week are inhospital, and about 15% of my work is industrial as both plant physician and private practitioner.

Surgical Referrals

I have consultive experience with most orthopedic and general surgeons in the Columbus area. This experience is partially the result of direct referral; the remainder is from industrial plant experience.

It is my distinct impression that surgeons in general, and orthopedists in particular, are reluctant to operate unless appropriate conservative therapy has not been effective. We frequently see patients with acute low back and neck pain syndromes. If outpatient management fails, we usually hospitalize the patient for about one week of conservative treatment. After this, we generally arrange a consultation with a surgeon or a physiatrist. The consultant usually opts for an additional week or so of conservative modalities. At that point, if the patient is not improving, both he and all the physicians are considering surgery. My observation is that the patient has to exert considerable pressure on the surgeon before he will consent to perform the surgery.

Among my other common experiences with orthopedic surgeons are hip "nailing," knee arthrotomy, and total joint replacement. All the patients who had these surgical procedures had been severely and permanently disabled prior to surgery; most of them derived marked benefit from it.

Hospital Utilization

For most of my 20 years of practice, I have been involved in utilization committee chart reviews. I have not seen any flagrant overutilization. Most of my reviews are medical, and the hospitalizations appear to be justified. Almost all of the overstays that I see result from the inability to discharge totally disabled, indigent patients.

There are many disadvantaged, disabled, elderly, and neglected patients without appropriate family structure. It usually is difficult and often impossible to place these patients in nursing homes when their medical problems are stabilized enough to discharge them. Thus, it appears to me that overutilization is clearly a social problem caused by lack of adequate posthospital facilities for the disabled indigent. There also is a lack of posthospital facilities for those patients with adequate financial resources, but this problem is much less severe.

Industrial Plant Experience

In the last eight months of 1977, I maintained a record of the patients returning to work from medical

Dr. Paul, Columbus, Active Attending Staffs, St. Anthony and Mount Carmel Hospitals; and Assistant Clinical Professor, Department of Family Practice, The Ohio State University College of Medicine.
Submitted March 29, 1978.

Table 1. Number and Diagnoses of Postoperative Cases

Diagnosis	Comment	No. of Cases
Herniorrhaphy	all middle-aged men	13
Cholecystectomy	all history of stones and pain	5
Breast lump		4
Knee meniscectomy		3
Carpal tunnel		2
Diverticulitis	1 obstruction, 1 perforation	2
Iliofemoral arterio-sclerosis obliterans		2
Prostate carcinoma		2
Hysterectomy	1 excessive bleeding, 1 endometriosis	2
Shoulder surgery		1
Ruptured biceps		1
Dupuytren's contractures		1
Skin graft		1
Lumbar disc with neuropathy		1
Lung carcinoma		1
Renal carcinoma		1
Rectal carcinoma		1
Colectomy for ulcerative colitis		1
Intestinal obstruction, hemorrhoidectomy		1
Appendectomy		1
Pyloroplasty vagotomy		1
Liver biopsy	cirrhosis	1
Supraclavicular biopsy	sarcoid	1
Cystoscopy	hematuria	1
Glaucoma		1
Cataract		1
Breast reduction		1
Bilateral varicose veins with pain		1
Lipoma (6″)		1
	Total	55

leave at the Columbus plant of Rockwell International. A brief history was taken and a pertinent physical examination made to evaluate the patient's suitability for his/her particular job. In this time interval, I attempted to make a retrospective judgment on the necessity for surgical or medical hospitalization for each patient. Given the facts at hand, I was unable to identify any inappropriate medical care or surgical procedure. From 83 post-hospital cases, I identified two questionables — one surgical case of submucosal resection and one patient who was hospitalized with chest pain which appeared to be a smoke screen for a general physical examination.

Table 2. Number and Diagnoses for Hospitalizations Other than Surgical

Diagnosis	No. of Cases
Myocardial infarction	5
Chest pain and rhythm disturbance due to arteriosclerotic heart disease	5
Low back pain, disabling	4
Pneumonia	2
Optic neuritis	1
Retinal vein occlusion	1
Upper gastrointestinal bleeding	1
Hemoptysis	1
Transient ischemic attack	1
C_{6-7} cervical neuropathy	1
Hepatitis	1
Unstable diabetes	1
Depression	1
Labyrinthitis	1
Total	26

Fifty-five other surgical cases were evaluated (Table 1) along with 26 medical hospitalizations (Table 2). From this data, it seems to me that the diagnoses speak for the necessity of acute hospital care in the majority of the cases. When the severity and disability of the case were uncertain, I questioned the returnee as to the extent of the disability prior to hospitalization. The responses in all of the cases left little doubt as to the appropriateness of the confinement.

Summary

It seems apparent to me that overutilization is at a very minimum in central Ohio. We all know that it occurs. It is primarily a result of social conditions and inappropriate expectations of the patient. As physicians, it is our responsibility to continue to educate our patients and the general public on these matters, to vigilantly review each other's records and methods, and to discuss our problems openly. We must be willing to support our convictions — not run away if one of our peers arrives with a lawyer at his side.

The extremely high quality of the physicians and hospitals in central Ohio represent a heritage of discipline, commitment, and cooperation between physicians and community leaders over a period of many years. It is up to us to continue these traditions with an even-handedness and lack of rhetoric so as to ensure our patients of the high quality and readily available care they have grown to expect. ☆☆☆



Does it influence your choice of a peripheral/cerebral vasodilator*?

- Vasodilan—compatible with coexisting diseases
- Vasodilan—compatible with concomitant therapy
- Vasodilan—compatible with your total regimen for vascular insufficiency

*Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily.

Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose, Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

U.S. Pat. No. 3,056,836

VASODILAN®

(ISOXSUPRINE HCl)

20-mg tablets

Mead Johnson PHARMACEUTICAL DIVISION

© 1978 MEAD JOHNSON & COMPANY · EVANSVILLE, INDIANA 47721 U.S.A. MJL7-4268

This asthmatic isn't worried about his next breath...



he's active he's effectively maintained on

QUIBRON®

Each capsule or tablespoon (15 ml) elixir contains theophylline (anhydrous) 150 mg and glyceryl guaiacolate (guaifenesin) 90 mg. Elixir: alcohol 15%

- theophylline for effective around-the-clock bronchodilator therapy
- 100% free theophylline

Indications: For the symptomatic relief of bronchospastic conditions such as bronchial asthma, chronic bronchitis, and pulmonary emphysema.

Warnings: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other compounds containing xanthine derivatives concurrently.

Precautions: Use with caution in patients with cardiac disease, hepatic or renal impairment. Concurrent administration with certain antibiotics, i.e. clindamycin, erythromycin, troleandomycin, may result in higher serum levels of theophylline. Plasma prothrombin and factor V may increase, but any clinical effect is likely to be small. Metabolites of guaifenesin may contribute to increased urinary 5-hydroxyindoleacetic acid readings, when determined with nitrosonaphtol reagent. Safe use in pregnancy has not been established. Use in case of pregnancy only when clearly needed.

Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 μg/ml.

How Supplied: Capsules in bottles of 100 and 1000 and unit-dose packs of 100; Elixir in bottles of 1 pint and 1 gallon.

See package insert for complete prescribing information.

Mead Johnson

PHARMACEUTICAL DIVISION

©1978 Mead Johnson & Company • Evansville, Indiana 47721 U.S.A. MJL 6-4220R3

THE OHIO STATE Medical Association Cancer Education Series*

Hospice

Cornelia M. Dettmer, M.D., Ph.D.

THE WORD "HOSPICE," originally a medieval term for a waystation to care for the weary traveler, now is used for a special program of total care for the dying patient. It embraces a philosophy that a dying patient be allowed to "live until death" in an environment of choice, surrounded by familiar persons, with the support of a caring community. A coordinated team of trained workers under the supervision of a physician provides physical, emotional, and spiritual support to the patient and to his family, with care continuing into the bereavement period.

The terminal patient is defined as one for whom no further active therapy is available for cure or control of disease. The life expectancy is in terms of weeks or months. A precise definition is important; it makes possible the realistic management of the patient and implies that no extraordinary measures are to be employed to prolong life (or as Dr. Cecily Saunders points out, not to prolong the act of dying). Over 90% of Hospice patients have cancer, due to the natural history of the disease; but patients with end-stages of renal, cardiac, respiratory, and other diseases also fit into this program.

Origin of Hospice Care

Hospice care originated in England under the supervision of Dr. Cecily Saunders. Her pioneer work at St. Christophers Hospice in southeast London started over ten years ago and has spread across Great Britain, with 25 Hospices now in operation. The first American Hospice was developed in New Haven, Connecticut. Presently, there are 12 Hospices in operation in the United States with ten cities in Ohio now actively organizing programs.

Death and dying are receiving wide coverage in the popular lay and medical press, especially since the publication of Dr. Elizabeth Kübler-Ross' pioneer work in this field. Physicians recognize that the patient is not dying because of a failure of their skill; they can appreciate the positive experience of a terminal illness when the patient and family are supported by a multidisciplinary team of trained health personnel.

Management of the Program

The total program is under direct supervision of a physician since pain control and skilled management of physical symptoms are the basis of successful care. One of the significant contributions of this program is the approach to pain control which emphasizes the use of medications on an around-the-clock basis before symptoms are severe, instead of giving medication only as needed.

There are two coordinated facets in the Hospice program — home care and inpatient care.

Home Care.— The special thrust is home care. A trained team of nurses, home health aides, clergy, volunteers, and supportive consultants in such fields as psychology, nutrition, physical therapy, and others, provide services as needed. It is interesting to note that in New Haven, Connecticut, where the outpatient Hospice program has been in effect for four years, 80% of the patients now die at home. This is in startling contrast to the national figure of 2% of patients dying at home.

Home care is cost effective. At New Haven, the average total cost of home care for three months of terminal care is under $800. This amount would cover only three or four days of acute hospital care. Reimbursement for cost of home care, however, is inadequate; and changes in health insurance coverage should be considered.

Inpatient Care.— The patient may require inpatient care for control of symptoms, readjustment of medications, or to rest the family members who are providing 24-hours-a-day care. Two approaches are possible for inpatient care. Ideally, there is a free-standing building, which is neither an acute care hospital nor a skilled nursing home, with cost per day somewhere between these two institutions' costs. The other approach is to locate a palliative care unit within an acute care hospital. Skilled nursing staff trained in terminal care are supplemented by the Hospice team of workers with coordination of the outpatient team.

Funding the care of the dying patient is a problem. Medicare does not provide payment for the dying patient, reimbursing only those hospitalization costs for active

Dr. Dettmer, Cincinnati, Director, Department of Oncology, The Christ Hospital; and Clinical Consultant in Radiology, University of Cincinnati College of Medicine.
Submitted July 20, 1978.

The Journal is pleased to publish this series through the cooperation of the OSMA Committee on Cancer and the American Cancer Society, Ohio Division, Inc.

therapy and rehabilitation. Unfortunately, at present, Hospice is not considered a legal entity for licensure or reimbursement. National and state legislative movements currently are underway to correct this.

Summary

The Hospice program is a response to the individualized needs of the dying patient with special problems. Continuity of care is provided 24 hours a day, seven days a week, with service extending through the bereavement period. The entire family unit is assisted in finding the strength to cope with this final stage of life.

Coordinators for the Ohio Hospice Association, their address, and telephone number are:

Ms. Ruth Wieditz
Visiting Nurses of Summit County
1200 McArthur Drive
Akron, Ohio 44320, 216/745-1601

Ms. Peggy Douglass
Staff-Patient Education
639 West Main St.
Barnsville, Ohio 43714

Miss Kim Devore
Hospice of Cincinnati, Inc.
P.O. Box 19221
Cincinnati, Ohio 45219, 513/721-1444

Ms. Linda Jewell
Cancer Center of N.E. Ohio, Inc.
11001 Cedar Ave.
Cleveland, Ohio 44106, 216/621-7300

Ms. Judith Patton
1930 Concord Road
Columbus, Ohio 43212, 614/488-3344

Ms. Betty Schmoll
Hospice of Dayton, Inc.
122 East Apple St., Room 430
Dayton, Ohio 45409, 513/223-0759

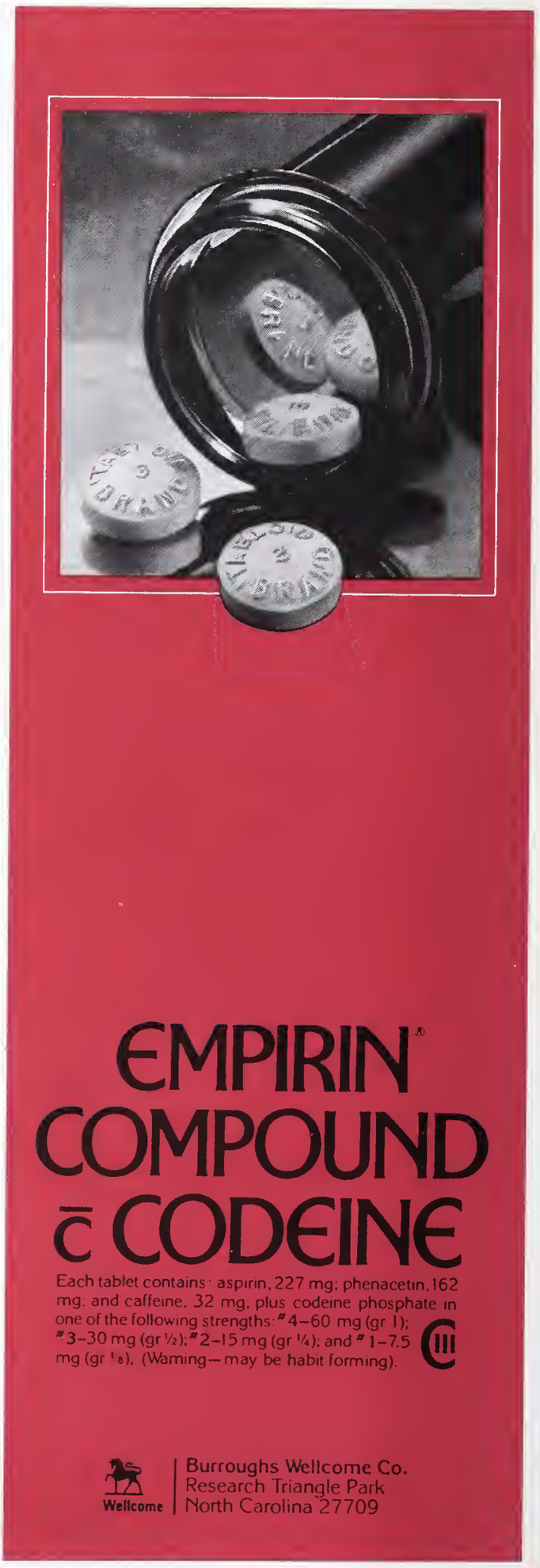
Sister Judith Ann
St. Joseph Hospital
205 West 20th St.
Loraine, Ohio 44052, 316/245-6851

Ms. Karen Sowards
Social Service Dept.
Scioto Memorial Hospital
180 South 27th St.
Portsmouth, Ohio 45662, 614/354-7580

Ms. Joanne Smith
Home Care Services
2615 East High St.
Springfield, Ohio 45501

Ms. Janet L. Blaufuss
Community Nursing Service
635 North Erie
Toledo, Ohio 43616, 419/247-6691

☆☆☆



The Ohio State Medical Association News

Poison Ivy — Not Oak — in Ohio

Physicians should be aware that although poison ivy is extremely common in Ohio, poison oak does not grow in the State at all. According to Norman E. Downing, Project Director, Trumbull Area Multi-Purpose Environmental Education Laboratory, poison ivy and poison oak are closely related plants which contain the same toxic principal, resulting in the same symptoms and requiring the same remedy.

Poison ivy may be found creeping along the ground, standing on its own to a height of five feet in rich moist soil, or vining up tall trees with the aid of hair-like aerial rootlets. The leaves may be large or small, shiny or dull, smooth-edged or with a few notches. A southern variety has leaflets that vaguely resemble oak leaves. Poison ivy and poison oak send warnings with the adage: "Leaflets three, let it be."

Although a person may never have contracted poison ivy previously, this does not ensure him immunity. It can be contracted anytime of the year from any part of the plant, however it is more prevalent during the summer. The oil of the plant must touch the skin to cause poisoning, and this may happen by handling shoes or a dog which may have passed through poison ivy.

Physicians Requested Not to Presign Prescriptions

The Medical Board of the State of Ohio requests that physicians not presign prescriptions, and further, that physicians not have the DEA (BNDD) number printed on prescription blanks. Instead, the DEA (BNDD) should be written in when the physician prescribes and signs the prescription for controlled substances. These steps should be taken to assist in the prevention of drug diversion and abuse.

OSMA Presents Rardin Scholarships

The Ohio State Medical Association has awarded its Thomas E. Rardin Family Practice Scholarships for 1978-1979. The $2,000 medical scholarship is given each year to two students who plan to become family physicians serving Ohio residents. The candidates are selected on the basis of character, integrity, intelligence, maturity, participation in community life, leadership, scholarship, financial need, and the desire to become a family physician. The scholarship is named in honor of Thomas E. Rardin, M.D., who spent over 40 years as a family practitioner in Columbus until his death in 1972. He was a founder of the Ohio Academy of Family Practice and his efforts helped establish family practice as an approved medical specialty.

This year's scholarship recipients are Cheri J. Skibicki, Toledo, and Gary J. Weisenberger, Columbus. Mrs. Skibicki received her registered nursing degree from the Lutheran Hospital School of Nursing, Ft. Wayne, Indiana, and completed her premedical training at the University of Toledo. She will attend the Medical College of Ohio at Toledo, where her husband is a second-year medical student. Upon graduation, they plan to establish a family practice in Deshler.

Mr. Weisenberger was an honors graduate of Findlay Senior High School and received his premedical training at The Ohio State University, where he earned a spot on the Dean's List every year. He will attend the University of Cincinnati College of Medicine.

Numerous Area MDs on Faculty of Northeastern Ohio Medical School

The Northeastern Ohio Universities College of Medicine (NEOUCOM) proudly has announced that more than 400 area physicians have received clinical faculty rank since the College began development of its six-year combined B.S./M.D. degree program. These physicians will share in teaching undergraduate medical students beginning this month when the charter class of students begins Year 4 of the College's program.

The students will begin their clinical undergraduate training in the following Akron hospitals associated with the College: Akron City, Akron General Medical Center, The Children's Hospital Medical Center of Akron, and St. Thomas Hospital Medical Center. Youngstown and Canton hospitals will become involved in clinical undergraduate training in subsequent academic years.

National Conference on Impaired Physician Scheduled This Month

The American Medical Association and the Minnesota Medical Association will host the Third National Conference on the Impaired Physician, September 29 - October 1, 1978 in Minneapolis. "Physican's Perception of and Attitude Toward Disabled Colleagues" will be the subject of the presentation of Robert G. Niven, M.D., at the opening session Friday evening. Dr. Niven surveyed 1,000 physicians attending courses at the Mayo Clinic, where he is a consultant in psychiatry. He will be followed by Rogers J. Smith, M.D., conference chairman, who will give a current overview of impaired physician programs,

(News continued on next page)

News *(continued)*

including results of a survey of state medical association programs.

The Saturday program will begin with a panel discussion on the legal aspects of impairment, chaired by Betty Jane Anderson, AMA Assistant General Counsel.

Among the 21 workshops are three on prevention and rehabilitation during medical training and three on the organization and functioning of medical society programs. Other topics to be covered include hospital programs for impaired medical staff members, licensing board activities, confrontation and treatment techniques, the role of state auxiliaries, psychiatry and impaired physicians, and medical marriages. Among the workshop leaders is Perry R. Ayres, M.D., Columbus, Chairman, OSMA Physician Effectiveness Program.

For further information, contact the Department of Mental Health, American Medical Association, 535 N. Dearborn Street, Chicago, Illinois 60610.

New Childbirth Concept Supported by National Health Care Groups

"Birthing rooms" would replace traditional labor, delivery, and recovery rooms under a new childbirth concept supported by the American Hospital Association (AHA) and other national health care groups. Built to resemble home-like surroundings, the birthing rooms are designed to conceal emergency medical equipment behind drapes and wall cabinets. In such a home-like atmosphere, the husband would be allowed to stay with his wife throughout the childbirth process and help her care for the baby. Instead of separating the mother from her child, the program would keep them in the same room so breastfeeding and holding of the baby could begin immediately after delivery. Organizations supporting the concept with the AHA are the American College of Obstetricians and Gynecologists, the American Academy of Pediatrics, the American College of Nurse-Midwives, and the American Nurses' Association.

New Pamphlets for the Blind

According to the American Foundation for the Blind, a person who has lost his sight because of diabetes can live independently and successfully provided he has been trained in the techniques of diabetes control and in skills for dealing with blindness. Some guidelines for medical and rehabilitation professionals are outlined in a pamphlet "Blindness and Diabetes," published by the Foundation. Techniques the blind diabetic can learn are described in another pamphlet entitled "Devices for Visually Impaired Diabetics," published by the Foundation and the New York Diabetes Association. Both pamphlets are available free from the American Foundation for the Blind, 15 W. 16th St., New York, New York 10011. "Diabetes and Blindness" also is available free in recorded form.

OSMA Art Show Winners

Painting

1st	Sydney H. Dinkin, M.D., Dayton
2nd	Anita Pescovitz, Cincinnati
3rd	Burt E. Schear, M.D., Dayton

Works on Paper

1st	Betty Schear, Dayton
2nd	Susan Clarke, Gallipolis
3rd	Noreen Horwitz, Dayton

Mixed Media

1st	Joan Weinberg, Dayton
2nd	Nobuhisa Baba, M.D., Columbus

Watercolor

1st	Frank Shively, M.D., Dayton
2nd	A. V. Black, M.D., Centerville
3rd	Robert E. Caporal, M.D., Dayton
3rd	Walter R. Lawrence, M.D., Springfield
3rd	Milton D. Feldman, M.D., Dayton

Sculpture

1st	Jack Weiland, M.D., Englewood
2nd	Raye Feldman, Dayton



WINDSOR HOSPITAL

A NONPROFIT CORPORATION

— ESTABLISHED 1898 —

Chagrin Falls, Ohio

247 - 5300

A hospital for the treatment of Psychiatric Disorders

High on a Hill-Top, Overlooking Beautiful Chagrin River Valley.

Accredited by Joint Commission on Accreditation of Hospitals.

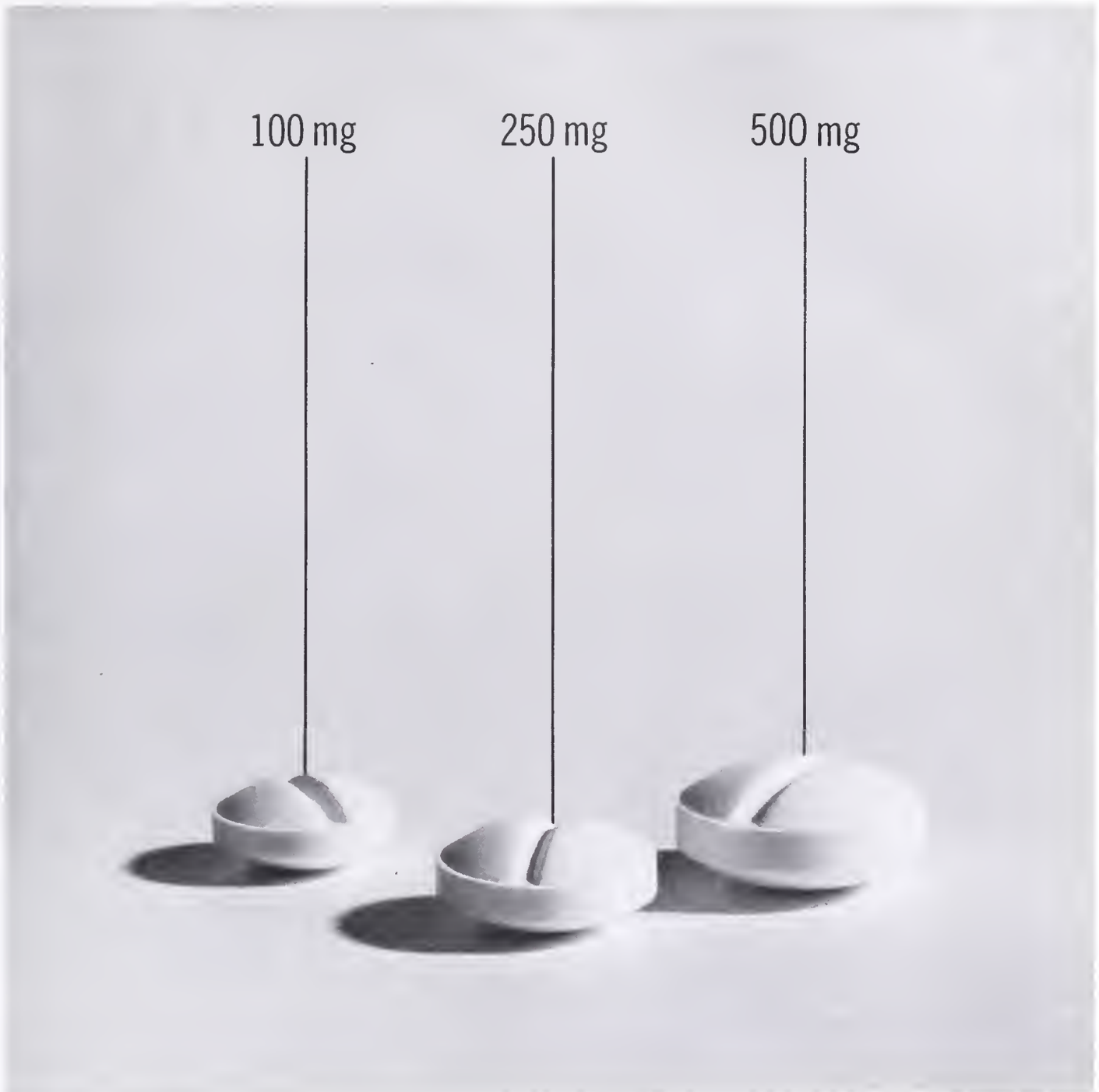
Booklet available on request.

FRIEDRICH A. LINGL, M.D. Medical Director

GUY H. WILLIAMS, JR., M.D. Medical Director Emeritus

HERBERT A. SIHLER Jr. President

MEMBER: American Hospital Association—National Association of Private Psychiatric Hospitals



Tolinase®
tolazamide, Upjohn

Please contact your Upjohn representative for additional product information.

Upjohn

J-5695-6

©1977 THE UPJOHN COMPANY

Colleagues in the News

Cincinnati MD Asst. Secretary of Defense for Health Affairs

ARNOLD M. LEFF, M.D., Commissioner of Health for Cincinnati, is the third Ohioan to occupy the position of Assistant Secretary of Defense for Health Affairs. Confirmed on August 4, Dr. Leff follows Robert N. Smith, M.D., Toledo (1976-1977), and Richard L. Meiling, M.D., Columbus (1949-1951).

In his five years with the Cincinnati Board of Health, Dr. Leff was responsible for a $17 million budget and the activities of 700 employees. His areas of responsibility included: environmental control and consumer protection, medical and dental services, mental health services, health education, and evaluation and planning. He also served as a Cincinnati Police Division physician.

Dr. Leff is a member of two advisory panels to the United States Congress: Advisory Panel on National Health Insurance, House Ways and Means Committee; and Advisory Panel on Water Quality, House Interstate and Foreign Commerce Committee.

Prior to becoming assistant commissioner and then commissioner of health in Cincinnati, Dr. Leff was Deputy Associate Director, White House Office for Drug Abuse Prevention. In that position, he had primary responsibility for planning and implementing programs designed to coordinate the criminal justice system and drug abuse prevention treatment activities; for managing a $100 million budget for drug abuse treatment, research, and education operated by the Departments of State and Defense and the Veterans Administration; and for planning and implementing drug abuse treatment and prevention activities in Thailand, Singapore, Republic of the Philippines, and Germany.

Dr. Leff holds several faculty appointments at the University of Cincinnati College of Medicine: Assistant Clinical Professor of Environmental Health, Lecturer in Pharmacology and Cell Biophysics, and Assistant Clinical Professor of Internal Medicine. He received his undergraduate and medical degrees from the University of Cincinnati, and completed a medical internship and a fellowship in internal medicine at its medical center.

Listed among his organizational affiliations is his membership on the Ohio State Medical Association's Committee on Mental Health. Dr. Leff also is a member of several committees of the Academy of Medicine of Cincinnati. Other organizations include the Ohio Public Health Association, the Ohio Health Commissioners' Association, the Health Planning and Resources Development Association of the Central Ohio River Valley Board of Trustees, the Board of Trustees of the U.S. Conference of City Health Officers, and the AMA.

MILLARD C. BEYER, M.D., Akron, received the Harriman Award for distinguished volunteer service, the highest honor bestowed upon a Red Cross volunteer. A maximum of three such awards may be presented yearly. A dynamic force in the Summit County Chapter for nearly 40 years, Dr. Beyer pioneered the development of an effective program for teaching swimming to the handicapped and disabled. Recently, he was elected an honorary member— member emeritus— of the Summit County Medical Society, the only person ever given this honor.

The Board of Trustees of Northeastern Ohio Universities College of Medicine have reelected their executive officers for a second year. Among the officers are **LEONARD P. CACCAMO, M.D.,** Director of Medical Education, St. Elizabeth Hospital Medical Center, Youngstown, vice-chairman; and **ROBERT E. TSCHANZ, M.D.,** Canton internist, secretary.

LAWRENCE R. ELLICK, M.D., Cleveland, has been named President of the Cleveland Society of Obstetricians and Gynecologists for 1978-1979. Other officers include **JAMES A. BOWMAN, JR., M.D.,** South Euclid, president-elect; **PIERRE W. MARTINBEAU, M.D.,** Cleveland, secretary; **JAMES M. SHAW, M.D.,** Fairview Park, assistant secretary; **EDWARD F. STERNAN, M.D.,** Euclid, treasurer; **DONALD E. HUBBELL, M.D.,** South Euclid, assistant treasurer; and **JOSEPH P. MARTIN, M.D.,** Cleveland, and **RONALD B. GOLDEN, M.D.,** South Euclid, members-at-large.

W. JAMES GARDNER, M.D., Cleveland, was honored during the first annual W. James Gardner Lectureship. Established by former Cleveland Clinic fellows in the Neurological Surgery Department, the event coincided with Dr. Gardner's 80th birthday. Dr. Gardner served as head of the Neurological Surgery Department from 1929 to 1962 and now holds emeritus status and serves as a consultant to the department. The first speaker was **WALLACE B. HAMBY, M.D.,** Cleveland, former head of the Neurological Surgery Department and the first clinic fellow to study under Dr. Gardner.

MICHAEL GREVER, M.D., Columbus, is one of 21 fellows to receive two-year research grants from the Leukemia Society of America, Inc. Dr. Grever is affiliated with The Ohio State University. The Society credits public concern for finding a cure for or control of leukemia as the reason for increased contributions that have enabled the agency to up its research allocations to a record high of $1.75 million.

JOHN S. McDONALD, M.D., is the new Chairman of the Department of Anesthesiology at The Ohio State University College of Medicine. Certified by both the American Board of Anesthesiology and the American Board of Obstetrics and Gynecology, Dr. McDonald also will assume the duties of Chief of Anesthesiology at University Hospitals. He comes to Ohio from positions as professor and vice-chairman of the Department of Anesthesiology, Valley Medical Center, Fresno, California; director of obstetric anesthesia, Women's Hospital, University of Southern California Medical Center; and director of research for obstetric anesthesia, Cedars/Sinai Medical Center, Los Angeles.

THOMAS F. MEANEY, M.D., Cleveland, has been re-elected Vice Speaker of the Council of the American College of Radiology. Dr. Meaney will also chair the Council Rules and Regulation Committee.

JACK H. MEDALIE, M.D., M.P.H., Cleveland, has been named the first Dorothy Jones Weatherhead Professor of Medicine at Case Western Reserve University School of Medicine. This is the first endowed chair in family medicine at any American university. Dr. Medalie noted that the response of Case Western Reserve medical students toward the new specialty has been positive, and for the second consecutive year, family practice has been the second most popular choice of residencies among the graduating students. Dr. Medalie is Chairman and Professor of Family Medicine at the School of Medicine and is recognized internationally for his research in epidemiology.

GERRY SCHAFFER, M.D., and **MARK SHEEHAN, M.D.,** both assistant clinical professors at Wright State University School of Medicine, have successfully completed board examinations. Dr. Sheehan completed the certifying examination in internal medicine, and Dr. Schaffer completed the subspecialty examination in gastroenterology.

RICHARD L. WENZEL, M.D., Toledo, received the John D. Porterfield Award for outstanding service to public health. This award is conferred by the Ohio Public Health Association to only one recipient yearly. Toledo and Lucas County Health Commissioner since 1970, Dr. Wenzel is the first health commissioner to be named to receive the award.

DAVID WROBLEWSKI, medical student at Case Western Reserve University School of Medicine, is one of ten recipients of $1,500 research fellowships funded by Syntex Laboratories. The purpose of the fellowship program is to help channel qualified medical students toward greater interest in dermatological research. Fellowship recipients are selected by the American Academy of Dermatology. Mr. Wroblewski was sponsored by **DAVID R. BICKERS, M.D.,** Director of Dermatology, Case Western Reserve University.

Letter to the Editor

To the Editor:

Declining childhood immunization levels and recent rubella and rubeola outbreaks in Ohio continue to be in the news. Thomas J. Halpin, M.D., of the Ohio Department of Health's Bureau of Preventive Medicine, has spearheaded a major effort to assure that the state's youngsters are adequately protected against the preventable diseases of diphtheria, pertussis, tetanus, poliomyelitis, rubella, and rubeola. With the enactment of SB 282, which is enthusiastically supported by the State Board of Education as well as the Ohio Department of Health, enforcement of minimum immunization levels among Ohio's school children is gathering greater momentum. The Ohio Department of Health, with its Advisory Committee on Immunizations, also is actively investigating ancillary means of increasing immunization services to the young.

Joining the Ohio Department of Health in promoting childhood immunizations are many other organizations, including the Ohio State Medical Association, the Ohio State Medical Association Auxiliary, the Ohio Chapter of the American Academy of Pediatrics, the Ohio Parent-Teacher Association, the Ohio Nursing Association, and the Ohio Department of Public Welfare. Much of these organizations' efforts have been directed toward the important area of health education for the public. In addition, the Department of Public Welfare is involved in programs providing immunization services; chief among them is the Early Periodic Screening, Diagnostic and Therapeutic Program (EPSDT).

The EPSDT program is implementing HEW Secretary Califano's Childhood Immunization Initiative by improving existing management systems to assure that all Medicaid-eligible children attain full immunization statuts appropriate for their age as soon as possible.

Revised EPSDT regulations, promulgated in September 1977, stipulate that the screening package will include "provision of immunizations appropriate for age and health history" at screening, rather than assessment and referral as necessary. Immunizations as an element of screening as opposed to treatment seem to be reasonable within the context of EPSDT which is, after all, a preventive health program.

All of this publicity and activity on behalf of childhood immunizations is welcomed by the family physicians and pediatricians of Ohio who, I am sure, will both support and provide medical leadership to existing as well as new programs aimed at strengthening this most important cornerstone of pediatric preventive medicine.

/s/Albert N. May, M.D.
Marion, Ohio
Advisory Committee on Immunizations
Ohio Department of Health

picolife

Life Insurance, With A Difference

Mortgage Protection



This low-cost coverage is growing in importance, as real estate values continue to soar. It is the only form of life insurance designed specifically to pay off the mortgage on your home, in the event of your death.

Pico Life's mortgage protection plan provides decreasing term life insurance in an amount equal to the outstanding balance on your mortgage. It is available for periods of 10, 15, 20, 25 or 30 years. As an added feature, it may be converted to a whole life or endowment policy without a medical examination as long as the policy is in full force, and while you are age 65 or less.

With Pico Life, your home is secure and you have the availability of a valuable life insurance policy in your later years.

This is one of the many Pico Life insurance plans designed for members of the OSMA. A Pico Life representative will be happy to give you personalized information about life insurance, with a difference.

picolife

Pico Life Insurance Company
6100 Channingway Boulevard
Columbus, Ohio 43227
Telephone (614) 864-0280

A Subsidiary of Physicians Insurance Company of Ohio (PICO)

THE OHIO STATE Medical Association

Proceedings of the Council

A regular meeting of the Council of the Ohio State Medical Association was held Saturday, July 8, and Sunday, July 9, 1978, at the OSMA Headquarters' Office, 600 South High Street, Columbus, Ohio.

Those present Saturday were: All members of the Council; all members of the Staff; Doctors Oscar W. Clarke, Gallipolis, and P. John Robechek, Cleveland; and David L. Rader, Vice President/Administration, the Physicians Insurance Company of Ohio.

Those present Sunday were: All members of the Council; Hart F. Page, C.A.E.; James E. Pohlman, Esq.; John Hartranft, Esq.; and Doctors James L. Henry, Oscar W. Clarke, P. John Robechek, and William R. Schultz.

Dr. Gaughan presented communications from Mrs. Ingrid May, outgoing president of the Auxiliary, and Dr. John H. Budd, outgoing president of the American Medical Association, thanking the OSMA for courtesies extended to them during their terms of office. Dr. Budd expressed his gratitude to the Association for his election to the honorary presidency of OSMA.

The Council received a letter dated May 12, 1978, from Jonathan J. Yobbagy, M.D., Steubenville, asking OSMA endorsement for a vacancy on the Ohio State Medical Board. The Council considered his request and noted that endorsements for this vacancy had been forwarded to the Governor on April 5, 1978, by request of the Council on April 1, 1978. It was the opinion of the Council that the time was too late to present additional names for the vacancy occurring in June 1978.

IMPLEMENTATION 1978 RESOLUTIONS

The Council discussed the resolutions adopted by the 1978 OSMA House of Delegates and by official action adopted the following provisions for their implementation:

- **Sub. Res. No. 3,** *Improved Communications Within the OSMA.*— Fall District Meetings were scheduled, beginning at 4 PM with a general session, cocktails at 5:30 PM, dinner at 6 PM, legislative session following dinner. The following schedule of district meetings **was approved:** *District 1,* September 25, Cincinnati; *District 2,* September 26, Dayton; *Districts 3 and 4,* September 20, Findlay; *District 5,* September 28, Cleveland; *District 6,* October 3, Youngstown; *District 7,* October 11, Cambridge; *Districts 8 and 9,* October 2, Athens; *District 10,* October 5, Columbus, and *Districts 11 and 12,* October 4, Medina.

  Dr. Dunsker requested that advance summaries of information be sent to the conferees along with specific agenda.

  The OSMA/AMA Update Meeting, with AMA officials present, was scheduled for Wednesday, November 29, to be held at 12 noon to 4 PM (with luncheon) in Columbus. It was suggested that county medical society delegates and alternates be invited.
- **Am. Res. No. 4,** *Automatic Termination of Membership.*— Print in Bylaws.
- **Res. No. 16,** *OSMA Dues Increase.*— Refer to Secretary-Treasurer; Chairman, Committee on Auditing and Appropriations; and Comptroller.
- **Sub. Res. No. 17,** *Funds for Defense.*— Refer to Ad Hoc Committee on Legal Assistance (first meeting held June 19, 1978) and to Ohio's Delegation to the AMA. (Resolution was referred in June 1978 by AMA House to AMA Board of Trustees. Board to report back to AMA House of Delegates Interim Session December 1978.)
- **Am. Res. No. 19,** *Michigan Medical Society vs. BC/BS.*— Staff to notify Michigan State Medical Society and the AMA Board of Trustees of this action.
- **Am. Res. No. 21,** *Accountability.*— Refer to an Ad Hoc Committee of the Council and the House of Delegates.
- **Res. No. 22,** *Confidentiality.*— Refer to Department of State Legislation and the Committee on Mental Health.
- **Res. No. 24,** *Collateral Source.*—Refer to Task Force on Professional Liability.
- **Res. No. 25,** *Tort Reform.*—Refer to Task Force on Professional Liability.
- **Res. No. 26,** *Counter Suits.*— Refer to Task Force on Professional Liability.
- **Am. Res. No. 28,** *Amendments to H.B. 682.*— Refer to Task Force on Professional Liability.
- **Sub. Res. No. 29,** *Letters by Third-Party Carriers.*— Refer to OMI Liaison Committee, *The Journal,* "OSMAgram," and Communications Department
- **Am. Res. No. 30,** *PICO.*— Refer to Task Force on Professional Liability.
- **Sub. Res. No. 32,** *Cost Containment.*— Refer to Committee on Cost Effectiveness, Committee on Government Medical Care and, Ohio's Delegation to the AMA. (This resolution was adopted by AMA House in June 1978.)
- **Res. No. 35,** *Doctors of Osteopathy.*—Council to refer second "Resolved" to Committee on Judicial and Professional Relations; first "Resolved" is moot.
- **Sub. Res. No. 36,** *Contraceptive and Prenatal Services for Minors.*— Refer to Department of State Legislation and Department of Health Education.
- **Sub. Res. No. 37,** *Principles of Medical Ethics.*— Refer to Ohio's Delegation to the AMA and the AMA Judicial Council.
- **Res. No. 40,** *Task Force to Study a State and Federal Tax Credit Reimbursement Plan.*—Form a Task Force and include a member of the Miami County Medical Society Legislative Committee.
- **Am. Res. No. 41,** *Sale of Cigarettes by Hospitals.*—Refer to Department of Health Education.
- **Sub. Res. No. 42,** *Health Planning Guidelines.*— Refer to Committee on Government Medical Care.
- **Sub. Res. No. 43,** *Certificate of Need.*— Refer to Department of State Legislation and Department of Federal Legislation.
- **Am. Res. No. 44,** *Rights of Lay Boards of Trustees to Mandate Policy to Medical Staffs.*— Refer to Joint Officers OHA, OSMA, and OOAPS; JCAH; and Ohio Delegation to the AMA. (Adopted by AMA House, June 1978.)
- **Am. Res. No. 45,** *Community Mental Health Centers.*— Refer to Committee on Mental Health.
- **Sub. Res. No. 49,** *Supervision of Physician Extenders.*— Refer

to Health Manpower Committee and report back to the House of Delegates of the OSMA in 1979.

- **Res. No. 50,** *Foreign Medical Graduates.*— Refer to Council for study.
- **Am. Res. No. 54,** *Establishment of National PSRO Council Guidelines.*— Refer to Committee on Government Medical Care and to Ohio's Delegation to the AMA. (Adopted by AMA House June 1978.)
- **Am. Res. No. 56,** *Physicians Responding to Emergencies in Hospitals.*— Refer to Department of State Legislation.
- **Am. Res. No. 58,** *Ohio Department of Public Welfare (Medicaid Division) Preadmission Review Forms.*— Refer to Department of Government Relations.

OSMA Ad Hoc Committee on Legal Assistance

Dr. Thomas submitted the minutes of the Ad Hoc Committee on Legal Assistance:

The OSMA Ad Hoc Committee on Legal Assistance met in St. Louis, Missouri, June 19, 1978, during the 1978 annual meeting of AMA's House of Delegates.

Those present were Chairman Robert G. Thomas; George N. Bates; Theodore J. Castele; President-Elect Thomas W. Morgan; all members of the Committee, and President John J. Gaughan. Also present were James E. Pohlman, Esq., legal counsel, and Hart F. Page, Executive Director.

The Committee discussed Sub. Res. 17-78 ("Funds for Defense," OSMA House of Delegates), which provided for the appointment of the Ad Hoc Committee.

It was noted that the AMA House currently was acting on a similar resolution submitted by the Ohio Delegation (later referred by the House to the AMA Board of Trustees).

The Ad Hoc Committee voted to advise The Council that a "fund for defense" is feasible if it is established under these guidelines:

(1) That the OSMA Council be established as the administering body.
(2) That contingency funds be budgeted for the purposes outlined.
(3) That the Council consider requests for assistance on a case-by-case basis.
(4) That only cases involving broad general principles of common concern to the membership be considered.
(5) That assistance in extraordinary cases be handled by special solicitation of the membership.
(6) That members and county medical societies show "good faith" by pursuing the litigation to a reasonable extent before soliciting funds from the OSMA.

ATTEST: Hart F. Page

The minutes **were approved** for implementation.

FINANCIAL AND MEMBERSHIP DEPARTMENT

Membership statistics, indicating a net gain of 442 members as of June 30 over the previous year, were presented by Mrs. Wisse.

Three members were granted dues waiver for 1978 under the provisions of Section 1, Chapter 2 of the Bylaws.

Committee on Auditing and Appropriations

The minutes of the Committee on Auditing and Appropriations meeting of July 7, 1978 were presented by Dr. Williams.

Dr. Williams reviewed the 1977 audit as prepared by Coopers and Lybrand, Certified Public Accountants. By official action, the audit **was approved** by the Council.

The Council voted that a resolution be prepared for submission by the Council to the 1979 House of Delegates to provide for a reduction in OSMA dues during the physician's first year of active practice. This concept is in line with a similar provision adopted by the American Medical Association in June 1978. Dr. Gaughan referred the matter to the Committee on Auditing and Appropriations with instructions to draft the resolution.

The Councilors were requested to inform the county medical societies that the computer-assisted dues billing services of the OSMA are available to assist them with billing and collection of federation dues.

The minutes, as a whole, **were approved.**

DEPARTMENT OF CONTINUING MEDICAL EDUCATION

Committee on Education

The minutes of the May 24, 1978 meeting of the Committee on Education were presented by Mrs. Dodson and **were approved.**

Committee on Scientific Work

The minutes of the June 11, 1978 meeting of the Committee on Scientific Work were presented by Mrs. Dodson and, with several modifications, **were approved** by the Council.

Annual Meeting Dates

The following annual meeting dates and locations **were approved** by the Council:

1979	May 12 - May 17	Columbus
1980	May 10 - May 15	Cincinnati
1981	May 16 - May 20	Cleveland (if possible)
1982	May 1 - May 6	Dayton
1983	May 14 - May 18	Columbus
1984	May 12 - May 17	Cincinnati
1985	May 18 - May 22	Columbus
1986	May 10 - May 15	Dayton
1987	May 16 - May 20	Columbus
1988	May 14 - May 19	Cincinnati
1989	May 20 - May 25	Dayton
1990	May 12 - May 17	Cleveland

Minutes of a June 15, 1978 meeting of the Foreign Medical Graduates Committee of the Cleveland Academy of Medicine were received for information.

Committee on Emergency and Disaster Medical Care

The minutes of the June 11, 1978 meeting of the Committee on Emergency and Disaster Medical Care were presented by Mr. Torrens and **were approved.**

DEPARTMENT OF GOVERNMENT RELATIONS

Committee on Cost Effectiveness

The minutes of the April 2, and the July 7, 1978 meetings of the Committee on Cost Effectiveness were presented by Mr. Gillen and **were approved.**

The Council voted that cost effectiveness programs be developed at hospital and county medical society levels.

It was requested by the Council that the "Voluntary Effort Newsletter" be utilized to convey information to local committees and county organizations.

It was recommended that recommendations on hospital and office cost savings be sent to county medical society presidents and hospital chiefs of staff.

Ohio Voluntary Effort

Meetings of the Committee sponsoring the "Ohio Voluntary Effort" (on cost containment) were reviewed by Mr. Gillen.

DEPARTMENT OF ORGANIZATION SERVICES

American Medical Association

A review of the 1978 annual meeting of the AMA House of Delegates was presented by Dr. Robechek and Dr. Clarke. Dr. Robechek submitted an eight-page document outlining the voting record of the Ohio Delegation on major issues during the AMA session.

Physicians Insurance Company of Ohio

Mr. Rader presented a report on the operation of the Physicians Insurance Company of Ohio, and answered a number of questions from members of the Council.

The Council adopted a motion requesting that the members of the PICO Board of Directors inform the members of the Council in advance of any discussion of other than occurrence-policy offerings by the insurance company.

PLIC Resolution

The following resolution concerning PICO Life Insurance Company of Ohio was adopted with one councilor abstaining:

WHEREAS, the Ohio State Medical Association (OSMA) formed the Physicians Insurance Company of Ohio (PICO) in 1976 to provide professional medical liability insurance and other types of insurance; and

WHEREAS, OSMA has, for many years, sponsored various life, accident and health group insurance plans for the benefit of OSMA members and their dependents and employees; and

WHEREAS, PICO, with the cooperation and encouragement of the Council of OSMA, has recently formed PICO Life Insurance Company (PLIC), a wholly-owned subsidiary of PICO, to offer life, accident and health insurance to members of the OSMA and others; and

WHEREAS, the officers of PICO and PLIC have informed the Council of OSMA that PLIC desires to furnish insurance for the OSMA sponsored group term life plans and group term life plan for corporate employers administered through Turner and Shepard, Inc. upon terms more favorable than presently existing; and

WHEREAS, OSMA desires to make available group insurance coverage to its members upon the most favorable terms possible;

NOW, THEREFORE, BE IT RESOLVED, that this Council hereby authorizes and directs its President to take whatever steps are necessary to effect the substitution of PLIC for the present insurer of such group term life plans and group term life plan for corporate employers, upon terms more favorable than presently provided, as determined by the President of OSMA; and

RESOLVED FURTHER, that the President and other officers of OSMA are hereby authorized and directed, in the name and on behalf of OSMA or otherwise, to execute all instruments, documents and certificates and take all such further and other action in connection with the resolutions hereinabove adopted as they may deem necessary, advisable or proper to effectuate the intent and purposes of these resolutions.

DEPARTMENT OF HEALTH EDUCATION

Committee on Cancer— Ohio Cancer Coordinating Committee, Inc.

Mr. Clinger presented the minutes of the March 29, 1978 meeting of the OSMA Committee on Cancer— Ohio Cancer Coordinating Committee, Inc.

The Council **approved** a recommendation that Dr. John Ackerman be urged to maintain the cervical cancer screening program at whatever possible level, with the Ohio Department of Health funding the program until major funding from other sources can be obtained.

The Council also **approved** the Committee's endorsement of the principle of the hospice concept.

The minutes, as a whole, were received for information.

Joint Advisory Committee on Sports Medicine

The minutes of the May 9, 1978 meeting of the Joint Advisory Committee on Sports Medicine were received for information.

Thomas E. Rardin Family Practice Scholarship Committee

The minutes of the June 14, 1978 meeting of the Thomas E. Rardin Family Practice Scholarship Committee were referred to the Committee on Auditing and Appropriations.

DEPARTMENT OF FEDERAL LEGISLATION AND PUBLIC POLICY

Ad Hoc Committee on Jenkins Memorial Clinic

The minutes of the March 29, 1978 meeting of the Ad Hoc Committee on Jenkins Memorial Clinic were presented by Mr. Edgar and were accepted for information.

Federal Legislation

Mr. Edgar discussed federal legislation as follows:

HR 6575.— Cost Control.

S 2410.— Kennedy amendments to Health Services Act (Certificate of Need for Physicians' Offices).

HR 8024 (Luken).— To permit physicians to establish trust funds for malpractice payments with payments into the fund tax deductible. The Council voted to support this proposal in principle.

HR 11611.— Drug Regulation Act. The Council voted to oppose this measure.

HR 10076.— The "right to privacy bill" was endorsed by the Council.

HR 13066.— To limit liability of health care providers; was endorsed.

HR 13109.— To modify the Social Security Act to provide for more equitable treatment of physicians under the system; was endorsed.

The Council also voted to support proposed legislation to indemnify organizations for legal expense and other

expenses involved in defending themselves against unwarranted and unsuccessful harassment by government agencies.

DEPARTMENT OF STATE LEGISLATION

Ohio State Medical Board

Dr. Clarke, a member of the Ohio State Medical Board, addressed the Council concerning both problems and opportunities before the Board. Dr. Gaughan thanked him for his report and offered to the Board, through Dr. Clarke, the assistance of OSMA.

Ohio General Assembly

Mr. Mulgrew reported on the Ohio General Assembly.

The Council voted to continue opposition to S.B. 344 and H.B. 1150, which would add more "consumers" to the Ohio State Medical Board.

Legislative Field Visits

Mr. Ayish reported on projected field work of the State Legislative Department and requested assistance from the members of the Council.

Antitrust Meeting

Mr. Mulgrew distributed the agenda for a July 20 meeting on antitrust problems to be sponsored by OSMA for county medical society executives and legal counsel.

COUNCILOR REPORTS

The Councilors reported on activities in their districts.

OCCUPATIONAL ALCOHOLISM PROGRAM FOR MEDICAL SOCIETY STAFFS

The Council voted to **approve** a proposed policy statement on an alcoholism program for medical society staffs, as submitted by the President of the American Association of Medical Society Executives.

There being no further business, the meeting was adjourned.

ATTEST: Hart F. Page, CAE
Executive Director

Journal Advertisers

American Medical Association 595
Breon Laboratories, Inc.....544
Brown Pharmaceutical Company, Inc....554, 555, 592
Burroughs Wellcome Co.....580
Daniels-Head & Associates, Inc. 547
Hurley Medical Center.....558
Immke Circle Leasing.....565
Eli Lilly and Company.....566
Mead Johnson.....577, 578
Medical Protective Company..573
Menendian Carpets.....590
Ohio Medical Indemnity.....570
PBP Data Systems.....569
Physicians Insurance Company of Ohio, Inc.....574
PICO Life.....586
Practice Productivity.....562
Roche Laboratories, Div. of Hoffmann-LaRoche, Inc. .....556, 557, Cover 2, Cover 3, Cover 4
Smith, Kline and French Labs. 560, 561
Stanley H. Kaplan Educational Center.....590
S-Tek 549
Turner & Shepard, Inc.....543
United States Air Force.....559
United States Navy.....568
Upjohn Pharmaceutical Company....583
Wendt-Bristol Company.....550
Windsor Hospital.....582



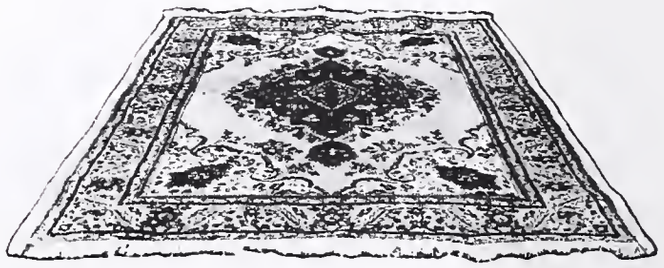
In Columbus
for over 65 years, since 1909,
K. A. Menendian
has been known for
the finest quality and best values in
ORIENTAL RUGS.

We carry a complete selection of rugs from mats to mansion sizes. Over 1500 rugs in stock from Iran, India, China, Pakistan, Turkey, etc.

See over 4,000 samples in our newly remodeled carpet showroom from Karastan and other fine mills.

We specialize in Oriental rug cleaning and repairing.

K.A.Menendian
1090 West Fifth Avenue
294-3345





the federal scene

(Courtesy the AMA Washington Office and OSMA Department of Federal Legislation)

Carter Issues Principles for National Health Plan

The nationalized health care merry-go-round took some dizzy spins in Washington when President Carter announced his ten principles for a national health plan. Even as the American Medical Association-Senator Edward M. Kennedy joint conference ("Focus on Positive Health Strategies") was being conducted in Washington July 25-27, a bitter behind-the-scenes struggle was going on between Carter forces and the Kennedy-labor cabal.

Irate over Carter's strategy of phasing in a national health care program through a series of steps, Kennedy, AFL-CIO President George Meany, and United Auto Workers President Douglas Frazer obtained a two-day delay of the announcement while attempting to get Carter to agree to "one-fell-swoop" legislation that would federalize the entire health care industry immediately, as promised them when Carter was campaigning for the Presidency. Otherwise, Carter's announcement would have hit the news media at the first full day of the conference rather than after it had adjourned.

Adding to the irony of the events was the fact that Kennedy, Meany, and HEW Secretary Joseph Califano were featured speakers at the AMA-Kennedy conference.

The American Medical Association lost no time in responding to the contents of the Carter plan. That response left the door open for AMA support of some of the principles, at the same time pointing out to the President those components AMA feels to be essential to any such legislation. In addition, the AMA high-leadership profile developed at the very successful AMA-Kennedy conference could bring other national organizations in health and related fields to look more expectantly toward medicine for continuation of that leadership.

The President's principles for a national health plan are as follows:

1. The plan should assure that all Americans have comprehensive health care coverage, including protection against catastrophic medical expenses.
2. The plan should make quality health care available to all Americans. It should seek to eliminate those aspects of the current health system that often cause the poor to receive substandard care.
3. The plan should assure that all Americans have freedom of choice in the selection of physicians, hospitals, and health delivery systems.
4. The plan must support our efforts to control inflation in the economy by reducing unnecessary health care spending. The plan should include aggresive cost containment measures and should also strengthen competitive forces in the health care sector.
5. The plan should be designed so that additional public and private expenditures for improved health benefits and coverage will be substantially offset by savings from greater efficiency in the health care system.
6. The plan will involve no additional federal spending until FY 1983, because of tight fiscal constraints and the need for careful planning and implementation. Thereafter, the plan should be phased in gradually. As the plan moves from phase to phase, consideration should be given to such factors as the economic and administrative experience under prior phases. The experience of other government programs, in which expenditures far exceed initial projections, must not be repeated.
7. The plan should be financed through multiple sources, including government funding and contributions from employers and employees. Careful consideration should be given to the other demands on government budgets, the existing tax burdens on the American people, and the ability of many consumers to share a moderate portion of the cost of their care.
8. The plan should include a significant role for the private insurance industry, with appropriate government regulation.
9. The plan should provide resources and develop payment methods to promote such major reforms in delivering health care services as substantially increasing the availability of ambulatory and preventive services, attracting personnel to underserved rural and urban areas, and encouraging the use of prepaid health plans.
10. The plan should assure consumer representation throughout its operation.

The following statement was issued by James H. Sammons, M.D., Executive Vice President of the American Medical Association, in response to the issuance of National Health Insurance Principles by the President:

The American Medical Association is pleased that the President appears to have recognized the many positive aspects and strengths of our health care system in the process of presenting his national health insurance principles. Many of the NHI principles announced by the President seem to be consistent in whole or in part with similar principles that have been endorsed by the American Medical Association. These include the need for comprehensive health care coverage, freedom of choice of physician, hospital, and health care delivery system, the provision of quality care, and the utilization of the private health insurance industry. The AMA has introduced legislation embodying these principles in the Congress since 1970.

We disagree sharply with Secretary Califano's critical comments about the existing health care delivery system and private health insurance coverage and with some of the statistics that he used. Taken another way, the converse of the statistics used by the Secretary paints a very positive picture of access to health care and record catastrophic and basic health insurance coverage. For example, rather than point to 20 million people without insurance coverage, the Secretary should have emphasized that nearly 200 million people have some level of coverage.

We agree with the need to restrain increases in the cost of care and to control the inflationary impact of any program that is considered by the Congress. In any such program, care must be taken that quality and access to care are not adversely affected. The American Medical Association is currently working with the Voluntary Effort program to restrain hospital costs. Recently, Dr. Tom E. Nesbitt, AMA President, urged physicians to limit fee increases.

Understandably, in the absence of a specific legislative proposal, it is difficult to comment in greater detail. For example, we have reservations about a reference to the need for a major reform of the health system without better understanding the details of that reform.

During the NHI debate, we would urge the private sector to continue to work to expand private health insurance availability and coverage, to maintain quality of care, and to voluntarily restrain the cost of care. ☆☆☆

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

When impotence is due to androgenic deficiency.

Android®/5 mg. Buccal/10 mg. Oral/25 mg. Oral

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric/eunuchoidism, eunuchism/post-puberal cryptorchidism.



Write for new double-blind study reprints and samples.

BROWN **THE BROWN PHARMACEUTICAL CO., INC.**
2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

Classified Ads

Rates: $3 per line. Display classified: $5 per line. Minimum 3 lines per insertion. Ads measure 8 lines to the inch. Box number reply: Flat $5 charge in addition to line cost for up to and including three insertions. (Covers cost of mailing replies which are kept confidential.) Forms close the 10th day of the month preceding month of publication. Address all ads Attention: Classified Ad Department, ***The Journal.***

To assure prompt delivery, when replying to an advertisement over a ***Journal*** box number, address letters as follows: Box (insert number), c/o ***The Ohio State Medical Journal***, 600 South High Street, Columbus, Ohio 43215.

AVAILABLE: Long-established physician's office for rental or property purchase. Excellent practice opportunity for general practitioner. Reply to: 329 Vassar Avenue, Elyria, Ohio 44035.

MEDICAL DIRECTOR— OCCUPATIONAL HEALTH/PREVENTIVE MEDICINE: Ohio Bell Telephone Company has embarked on an expanded occupational health program and is seeking someone who is interested in participating in the organization's development and growth. This position is located at the company's headquarters in Cleveland. Internal medicine and/or occupational health background is helpful but not necessary; interest and desire is most important. Excellent fringe benefit package includes life, health, dental, and professional liability; pension; savings plan; paid vacations, etc. Salary commensurate with other industries and in keeping with background training and experience. Send curriculum vitae to G. H. Franck, M.D., Corporate Medical Director, Ohio Bell Telephone Company, 100 Erieview Plaza, Room 910, Cleveland, Ohio 44114.

An Equal Opportunity Affirmative-Action Employer

FAMILY PRACTICE: Partners need associate in busy practice in fast-growing community. Southwest Ohio near city hospitals and medical schools. Write or call collect: G. K. Ohlhauser, M.D. or Thomas E. Fox, M.D., 309 Reading Road, Mason, Ohio 45040, phone 513/398-6010.

NEW OFFICE SPACE: Available in rapidly growing area of Ohio, 25 miles west of Cleveland, one block from a newly expanded 400-bed hospital. Please call 216/322-3947 or 216/323-8458 for further information.

GENERAL PRACTICE PHYSICIAN WANTED: Office space available. $100,000 first-year potential. Northcentral Ohio, population area 25,000. Ideal environment, excellent sports, recreational facilities, boating nearby. Midway Cleveland-Toledo, 100 miles north Columbus. Modern 68-bed hospital. Good schools. Brochure on request. Write T. R. Ball, M.D., Box 309, Bellevue, Ohio 44811.

OPHTHALMOLOGIST: Board-certified eligible ophthalmologist sought to associate in an established practice. Major regional medical center consisting of 43 multispecialty physicans in northwest Ohio. Top salary and excellent fringe benefit program along with all corporate benefits. Please forward curriculum vitae, salary requirements to Box 837 c/o Ohio State Medical Journal.

MARION, OHIO: Excellent opportunities in Central Ohio. Existing and new, solo, partnerships, or association practices available and seeking physician support. Top compensation— reliable cross coverage. Exceptionally attractive, 225-bed, well-equipped regional medical center hospital within walking distance from offices. Industry and agriculture support city/45,000; county/65,000; and total trade area/250,000. Excellent schools and residential areas. Fifty-minute, easy drive to Columbus. Active need for—

FAMILY PRACTICE
INTERNAL MEDICINE
OTOLARYNGOLOGY
PEDIATRICS
INDUSTRIAL/OCCUPATIONAL
EMERGENCY MEDICINE

We are seeking either rural or city-oriented physicians. Send C.V. or contact— **ROBERT FLINT,** Marion General Hospital, **MARION,** OHIO 43302 — or call 614/387-8810 or 387/5442 any time.

PEDIATRICIAN WANTED: For 47-man multispecialty group located in a prosperous Central Ohio community. Present Department includes four pediatricians providing 37,000 outpatient visits yearly. Attractive salary and unusual fringes, including retirement program; early partnership with no financial investment. Send C.V. or call collect to Albert N. May, M.D. or Bruce Dyer, Executive Director, F. C. Smith Clinic, 1040 Delaware Avenue, Marion, Ohio 43302, phone 614/387-0850.

INDUSTRIAL PHYSICIAN: A challenging and exciting position available as staff M.D. for Marion Regional Health Services, Inc. in Marion, Ohio. We furnish complete occupational programs to include preemployment physicals, job injuries, and occupational hazzard evaluation to many small and moderate-sized plants in Central Ohio. We are anxious to expand into other areas, including preventive medicine, ecological medicine, environmental health, toxicology, and patient education. Marion is a pleasant, rural community of approximately 40,000 to 50,000 that serves as a headquarters for numerous manufacturers of heavy equipment, appliances, packing containers, pet foods, metal products, and agricultural commodities. Competitive salary with excellent fringe benefits including a pension and profit-sharing plan, life insurance, and medical benefits. No night or weekend calls. Board certification or industrial medical experience is not required. Contact Nelson H. Kraus, M.D., Medical Director of Marion Regional Health Services, Inc., 1142 Independence Ave., Marion, Ohio 43302, phone: 614/387-6466.

108 ACRES: Of beautiful rolling land between Columbus and Marysville along Millcreek. Large percentage tillable. Nice three-bedroom, 1½ bath, two-story home with basement, nearly new horse barn (really deluxe), hay barn (bank style), other buildings, all in super condition. Beautiful setting with trees, meandering creek, etc. Reminds you of something you might see in a painting. Listed at $2,500 per acre with terms. Call Rosemary Smith 614/876-5496 or 876-1112.

PHYSICIAN'S ASSISTANT: B. S. degree, member AAPA. Desires position in Ohio area; especially interested in orthopedics. Contact: M. Lewis, 408 Plum Rd., Cincinnati, Ohio or call 513/251-0905.

(EDITOR'S NOTE: The Journal presents the above classified advertisement to its readers as an announcement of the physician's assistant and assumes no responsibility for the statements made.)

FAMILY PRACTICE-PEDIATRICS

Openings for physicians that want to devote their time 100% to family-oriented medical care with no administrative responsibilities, in a new health care center with full facilities for outpatient care located in northwest Ohio near eight hospitals and a major medical school. Excellent hours and compensation with good comprehensive benefits, including continuing education opportunities. The center is located within minutes of Lake Erie. Please forward C.V. or call Dr. David T. Curtis, c/o Health Plus/The Toledo Plan, 4346 Secor Road, Suite 105, Toledo, Ohio 43624, phone: 419/473-0500.

(Classified Ads continued on next page.)

AMBULATORY CARE CENTER — EMERGENCY DEPARTMENT STAFF PHYSICIAN, ATHENS, OHIO: 20,000 annual patient visits. Flexible scheduling, minimum guarantee/monthly bonus, excellent fringes. Contact Eric Jenison, M.D., O'Bleness Memorial Hospital, Athens, Ohio 45701, or call toll-free 800/325-3982 for details.

FAMILY PRACTICE — RURAL PRACTICE: Northwest/central rural/agrarian community of 1200/1500 needs family practice physician. Practice could expand to cover 3000/3500 population area. No physician now practicing. Community will support. Major regional hospital within driving distance. Contact *ROBERT FLINT*, **MARION HOSPITAL, MARION, OHIO** 43302, phone: 614/387-8810 or 387-5442.

EMERGENCY PHYSICIANS: Full-time, immediate and near-future openings exist in Ohio and Pennsylvania. Excellent pay, benefits, and malpractice insurance. Emergency Room experience and state license required. For details, forward C.V., etc., to Box 835 c/o Ohio State Medical Journal.

OB/GYN: Well-established busy OB/GYN practice in Northeast Ohio for sale. Grossing over $150,000 per year. Fully equipped office and three examining rooms with the latest OB/GYN equipment. Will introduce you to patients. Price and terms negotiable. If interested, call 216/257-7227, Mentor, Ohio.

EMERGENCY PHYSICIANS: Full-time, career-oriented, northeast Ohio. Compensation commensurate with experience and training. Liberal fringe benefits, including professional liability insurance. Write: J. J. Cahill, M.D., 36001 Euclid Ave., Willoughby, Ohio 44094. Phone: 216/946-4546.

SURGEON: Board-certified, wants to slow down. Seeking position with minimum 3-months, noncontinuous vacation annually. Reply to Box 832 c/o Ohio State Medical Journal.

APPRAISAL SERVICE: Medical equipment and instruments. C. L. Benjamin, 941 Shorewood Dr., Medina, Ohio 44256, phone: 216/725-4044.

(EDITOR'S NOTE: The Journal presents the above classified advertisement to its readers as an announcement and assumes no responsibility for the statements made.)

PLACEMENT OPPORTUNITIES: Ohio, Pennsylvania. Excellent positions available now and in the near future for private, group, and hospital associated-practices in Internal Medicine, Urology, Ophthalmology, Family Practice, General Surgery, Orthopedics, Pediatrics, Psychiatry and Otolaryngology. Confidential service by licensed placement agency. No fees charged to you. For details, forward C.V., etc. to Box 834 c/o Ohio State Medical Journal.

PLAIN CITY AREA: Fantastic multi-level, four-bedroom home located on almost 2 acres, overlooking stream. Super home offering many extras with 2½ baths, large family room with WBFP, formal living room, two-car garage, separate rear-door garage for yard tractor. Listed at $106,000. Call Rosemary Smith at 614/876-5496 or 876-1112.

PRACTICE - CLINIC - PRIMARY CARE: Ideal group practice location. Industrial, ranching community. Will sell inventory— appraised value—, building, land. Will introduce. Send curriculum vitae to: Robert C. Miller, M.D., 101 Parking Way, Lake Jackson, Texas 77566, phone: 713/297-2441.

WANTED: Partner to race two-year-old thoroughbred this fall. Contact: Tom Reynolds at 614/837-1242.

(EDITOR'S NOTE: The Journal presents the above classified advertisement to its readers as an announcement and assumes no responsibility for the statements made.)

MEDICAL OFFICE SPACE: Now under construction, Woodfox Center, corner of Mack & Winton Rds., Fairfield, Ohio. ¾ mile from new Mercy South Hospital. Call: Heckman & Gilliland 614/885-7300.

FACULTY POSITIONS: MEDICAL COLLEGE OF OHIO. The Department of Family Medicine is actively recruiting two board-certified family physicians to join an established program. The available positions are (1) undergraduate director and (2) assistant residency director. Competitive salary and benefits. Harry E. Mayhew, M.D., Chairman, Department of Family Medicine, Medical College of Ohio, C.S. #10008, Toledo, Ohio 43699.

An Equal Opportunity Employer
Male/Female

PHYSICIAN'S ASSISTANT OR NURSE PRACTITIONER: To assist me in my private practice. Working conditions and pay flexible. Located in Northeast Ohio. Reply Box 836 c/o Ohio State Medical Journal.

ANESTHESIOLOGIST WANTED: Full-time, incorporated practice. Suburban Cleveland location, 400-bed hospital; all types of anesthesia. We have five anesthesiologists and ten nurse anesthetists. Liberal fringe benefits, retirement plan, vacation, and time off after call. Send application and resume to: Box 833 c/o Ohio State Medical Journal.

NEW MODERN HOUSE: Tortola, British Virgin Islands. Fully equipped for four persons. Vacation rental weekly, winter or summer. Maid service. Unparalleled situation and climate. Photographs available on request. Contact: Raynes, 105 West Princeton, Youngstown, Ohio 44507.

PEDIATRICIAN, OB-GYN, INTERNIST & SURGEON: Board-eligible or certified. Needed immediately for established multispecialty group in mid-Ohio community of 60,000, next to 500-bed hospital. Liberal payment and benefits. Contact: J. Harold King, M.D., 295 Glessner Ave., Mansfield, Ohio 44903, phone 419/525-1111.

EMERGENCY MEDICINE: Ohio and western Pennsylvania. Occasional part-time or full-time work available. Excellent remuneration and flexible scheduling. Ohio or Pennsylvania license required. Contact: James Ginter, Regional Administrator, 931 Chatham Lane, Columbus, Ohio 43221, phone: 614/457-9761.

GENERAL MEDICAL OFFICES AVAILABLE FOR RENT: In Hartville, reportedly the fastest growing township in Ohio. New construction permitting individual furnishing. Physically attached to Cancer Center with diagnostic x-ray, laboratory, and pharmacy facilities. Contact George N. Swallon Agency, Canton, Ohio, 216/456-3495, or inquire of R. K. Loeffler, M.D., 650 South Prospect, Hartville, Ohio 44632.

LOOKING FOR A POSITION?
SEEKING AN ASSOCIATE?
Contact the OSMA Placement Service
600 S. High Street, Columbus 43215
Telephone: 614/228-6971

CME



AMA-OHIO STATE MEDICAL ASSOCIATION BRINGS CME TO OHIO

AT SAWMILL CREEK OCTOBER 20-22, 1978

The Ohio State Medical Association invited the AMA to cooperate in a continuing medical education program for its members. Non-AMA members are welcome, where amid 300 acres of natural woods and ponds, Sawmill Creek offers an ideal environment for learning.

Classes will be over at midday, so reserve your afternoons and evenings for Sawmill's abundant activities. For indoor swimming, Sawmill has a beautiful pool. There are also adjacent saunas and a hydrotherapy pool.

If the autumn weather is as beautiful as it should be, head for Lake Erie for boating, fishing, or strolling along the 3,000 feet of white sand beach. Tennis or golf anyone? Sawmill Creek has an 18 hole championship course and three all-weather tennis courts (contact hotel for advance reservations). Paddle tennis, table tennis, and billiard rooms round out the sports activities.

Gracious rusticity and comfortable elegance are the hallmarks of Sawmill Creek. These qualities are reflected in the restaurants that range from the Bird Cage with its verdant foliage to the Crow's Nest which features delectable gourmet fare and nightly entertainment. Camaraderie and superb cuisine—the perfect way to end your study day.

Friday afternoon and Saturday afternoon afford plenty of time to visit several well known locations, the Tiffin Glass Works and the home of Thomas A. Edison.

SEE OVERLEAF FOR CME COURSE REGISTRATION FORM & FOR HOTEL REGISTRATION FORM
or phone inquiries to: **AMA Department of Meeting Services at (312) 751-6503.**

CME AT SAWMILL CREEK—OCTOBER 20-22, 1978

Courses Offered at Huron, Ohio

(M—Member; N—Nonmember)

Friday, 8:00 A.M.-1:00 P.M. (each 5 hours: M—$55; N—$80)

OOY1—Peripheral Vascular Disease
OOY2—Basic Life Support
OOY4—Radiology—Chest X-Rays, Flat & Upright Abdominal
OOY5—Preventive and Predictive Medicine in GI Diseases

Saturday, 8:00 A.M.-1:00 P.M. (each 5 hours: M—$55; N—$80)

OOY6—Dermatology for the Non-Dermatologist
OOY8—Cardiac Arrhythmias, Recognition, Significance & Treatment
OOY9—Acid-Base, Fluid & Electrolyte Balance
OY10—Human Sexuality

Sunday, 8:00 A.M.-1:00 P.M. (each 5 hours; M—$55; N—$80)

OY11—Office Gynecology
OY12—Headache
OY13—Pulmonary Diseases
OY14—Physicians Practice Management
OOY3—Important Recent Advances in Drug Therapy

Saturday & Sunday, 8:00 A.M.-4:00 P.M. (14 hour, 2-day course: M—$150; N—$220)

OOY7—Advanced Life Support (Cardiopulmonary Resuscitation—CPR)

CME COURSE REGISTRATION FORM AMA'S HURON CME REGIONAL MEETING

Please circle the course, by codes, that you wish to attend:*

Friday OOY1 OOY2 OOY4 OOY5

Saturday OOY6 OOY7 OOY8 OOY9 OY10

Sunday OOY3 OY11 OY12 OY13 OY14

Payment must accompany choice of courses requested on this registration coupon.

*Courses OOY1, OOY2, OOY3, OOY4, OOY5, OOY6, OOY8, OOY9, OY10, OY11, OY12, OY13, OY14 are 5 hours each presented once: $55 each. Course OOY7 is a 14-hour, 2-day course, presented only once. All medical students and residents are entitled to a 50% discount on course registration fees. ($10 per credit hour of Category 1 is standard rate.) Breakfast only will be provided for all course participants.

NAME _____
(please print or type)

OFFICE ADDRESS _____

CITY _____

STATE/ZIP CODE _____

OFFICE PHONE NO.(_____)_____

Mail this tear-out form with your check to:

American Medical Association
Department of Meeting Services
535 North Dearborn Street
Chicago, Illinois 60610

Hotel Reservations/Sawmill Creek Lodge AMA-Ohio State Medical Association Regional Meeting—October 20-22, 1978

Return to: **Sawmill Creek Lodge,**
Room Reservations Department
P.O. Box 358, Huron, Ohio 44839

Note: September 22, 1978, is the last date that bedrooms are being held for this meeting. After this cut-off date, reservations will be accepted only if rooms are available.

Circle your selection of accommodations:
Single Occupancy = $42 per day.
Double Occupancy = $48 per day.
These rates are subject to a 4% state tax.

Deposit required for confirmation. Please enclose check (payable to the Sawmill Creek Resort) in the amount of $42 or $48 to cover the room deposit. In the event of cancellation, your deposit will be refunded if Sawmill Creek is notified 48 hours in advance of the date of your planned arrival. Deposit applies to the last day of your reservation only.

List ages of children under 12 years old _____

Total number of persons _____

Arrival Date _____ Time _____ AM PM

Departure Date _____ Time _____ AM PM

Check for $_____ is enclosed for the Sawmill Creek Resort.

NAME _____

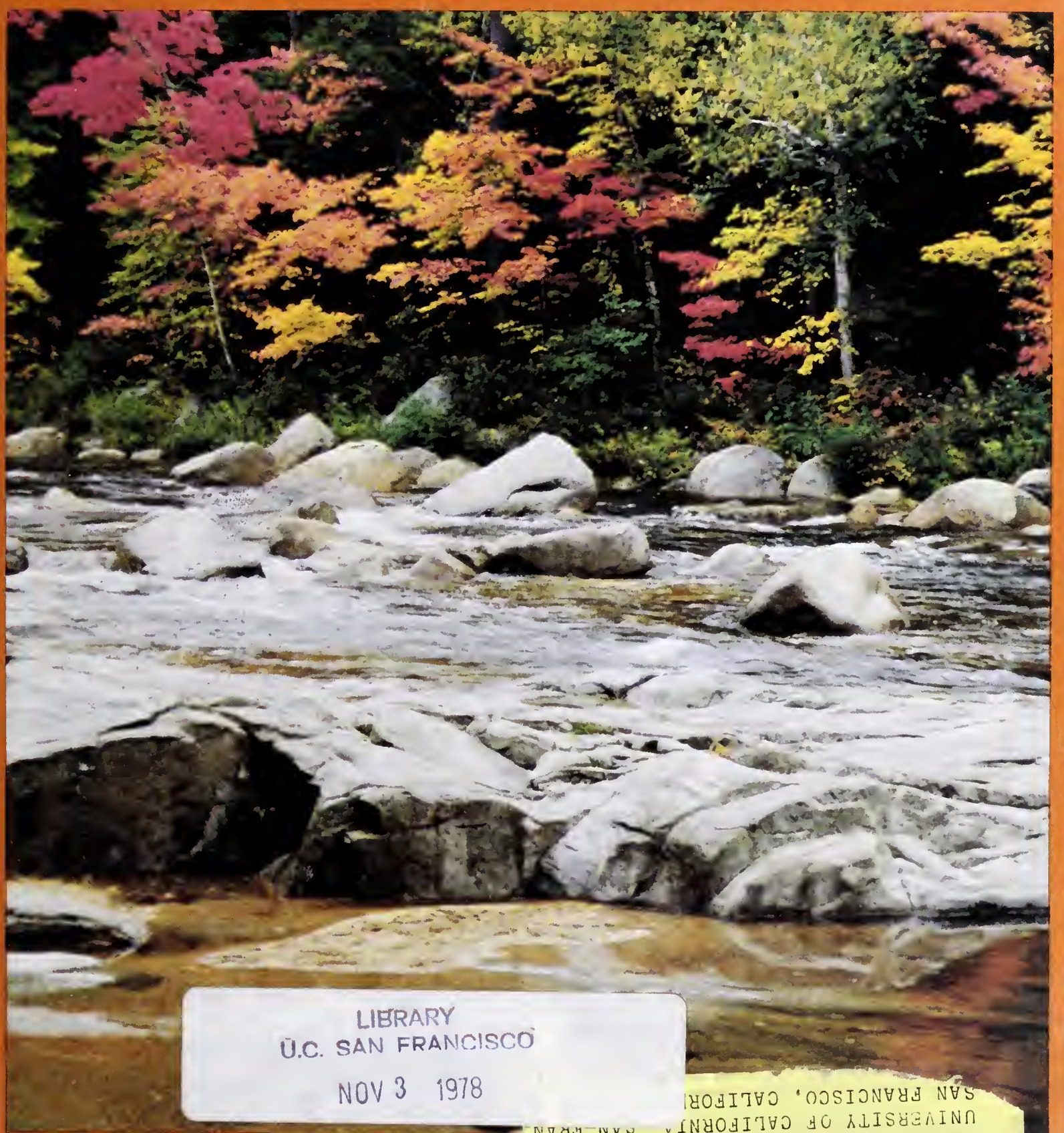
OFFICE ADDRESS _____

CITY/STATE/ZIP CODE _____

OFFICE PHONE NO. (_____)_____

OCTOBER 1978
Volume 74, Number 10

THE OHIO STATE Medical Journal



LIBRARY
U.C. SAN FRANCISCO
NOV 3 1978

THE LIBRARY
ACQUISITIONS DIVISION
UNIVERSITY OF CALIFORNIA SAN FRAN
SAN FRANCISCO, CALIFOR

PUBLISHED BY THE OHIO STATE MEDICAL ASSOCIATION

When cystitis recurs... **Bactrim fights uropathogens**



at 3 important sites

the Bactrim three-system counterattack...

① urinary tract

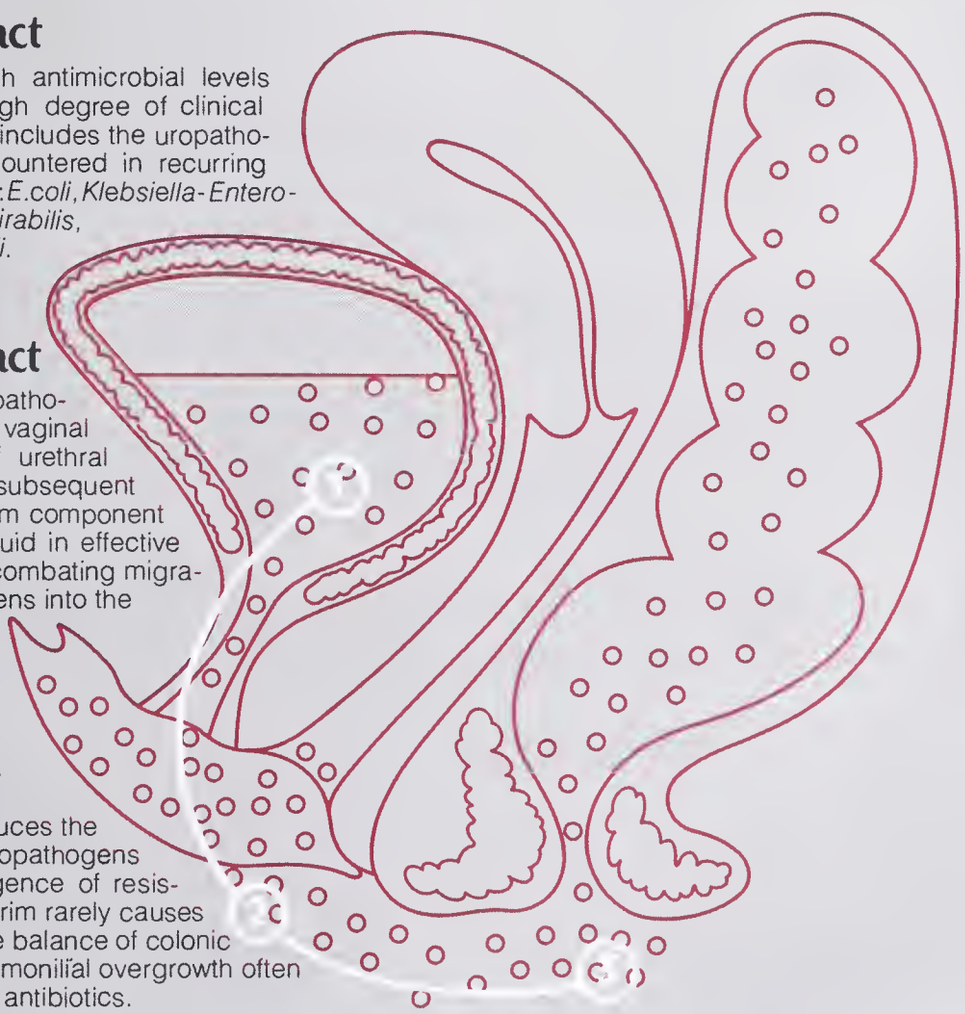
Bactrim provides high antimicrobial levels in the urine and a high degree of clinical efficacy. Its spectrum includes the uropathogens most often encountered in recurring urinary tract infections: *E.coli, Klebsiella-Enterobacter* and *Proteus mirabilis, vulgaris* and *morganii*.

② vaginal tract

Bactrim combats uropathogens colonizing the vaginal introitus, a source of urethral contamination and subsequent cystitis. Its trimethoprim component diffuses into vaginal fluid in effective concentrations, thus combating migration of urinary pathogens into the urinary system.

③ lower intestinal tract

Bactrim markedly reduces the colonic reservoir of uropathogens with negligible emergence of resistance. Moreover, Bactrim rarely causes adverse effects on the balance of colonic flora...seldom causes monilial overgrowth often associated with many antibiotics.



to clear her infection and combat reinfecting organisms

BACTRIM™ DS DOUBLE STRENGTH TABLETS

(160 mg trimethoprim and 800 mg sulfamethoxazole)

JUST ONE TABLET B.I.D. FOR 10 TO 14 DAYS

ROCHE

Please see summary of product information on next page.



When cystitis recurs...

BACTRIM™ DS DOUBLE STRENGTH TABLETS

(160 mg trimethoprim and 800 mg sulfamethoxazole)

fights uropathogens at 3 important sites

- ☐ Highly effective against most urinary invaders
- ☐ Indicated even in presence of structural abnormalities and vesicoureteral reflux (so clinically significant in children)
- ☐ Indicated in patients as young as two months of age
- ☐ Dual action minimizes microbial resistance
- ☐ Generally well tolerated, with or without food
- ☐ Easy-to-follow b.i.d. dosage schedule
- ☐ During therapy, maintain adequate fluid intake; perform frequent CBC's and urinalyses with microscopic examination
- ☐ Contraindicated during pregnancy and the nursing period, in patients hypersensitive to its components and in infants under 2 months of age

ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register*, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended, therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary tract infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100, Tel-E-Dose® packages of 100; Prescription Paks of 20. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500, Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

OSMA OFFICERS

President
JOHN J. GAUGHAN, M.D.
7911 Detroit Avenue
Cleveland 44102

President-Elect
THOMAS W. MORGAN, M.D.
P.O. Box 344
Gallipolis 45631

Past President
WILLIAM M. WELLS, M.D.
241 Hudson Avenue
Newark 43055

Secretary-Treasurer
ROBERT G. THOMAS, M.D.
630 East River Street
Elyria 44035

EDITORIAL STAFF

Consulting Medical Editor
Richard L. Meiling, M.D.

Managing Editor and Business Mgr.
Hart F. Page

Executive Editor and Executive Business Manager
Linda A. Porterfield

Editorial Assistant
Mary Lou Brady

Communications Editor
Rebecca J. Doll

Continuing Medical Education Editors
Gail E. Dodson
David C. Torrens

Federal Legislation Editor
Charles W. Edgar

Field Service Editor
Robert E. Holcomb

Government Relations Editor
Herbert E. Gillen

Health Education Editor
Robert D. Clinger

Membership Editor
Katherine E. Wisse

Organization Services Editor
Jerry J. Campbell

State Legislation Editors
D. Brent Mulgrew, J.D.
Richard A. Ayish

Address All Correspondence, Address Change, & Reprint Request (unless otherwise noted): Executive Editor, The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215. Phone: 614/228-6971.

Published monthly under the direction of The Council for and by members of The Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215, a scientific society, nonprofit organization, with a definite membership for scientific and educational purposes.

1979 Subscription: $15 per year, single copy $2 (outside U.S. $20 and $3).

Entered as second class matter July 5, 1905, at the Post Office at Athens, Ohio, under the Act of Congress of March 3, 1879. Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918. Second-Class Postage Paid at Athens, Ohio.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertisers must conform to policies and regulations established by The Council of the Ohio State Medical Association.

Publication office: 900 East State Street, Athens, Ohio 45701.

Printed by
The Lawhead Press, Inc., Athens, Ohio

VOL. 74 OCTOBER 1978 NO. 10

THE OHIO STATE Medical Journal

Clinical and Scientific Articles

MANAGEMENT OF RETINAL DETACHMENTS 617
William H. Havener, M.D., Columbus

GENETIC SERVICES IN OHIO. A REGIONAL APPROACH 623
Antoinette Parisi Eaton, M.D.; John H. Ackerman, M.D., M.P.H.; Alice S. Linyear, M.D., M.P.H.; and Eleni Sfakianaki, M.D., Columbus

VALPROIC ACID: A BRIEF REVIEW 629
Robert P. Cruse, D.O., Hershey, Penna.; A. David Rothner, M.D.; Gerald Erenberg, M.D.; Charles Henry, Ph.D.; and Kathleen Jugenheimer, B.S.N., Cleveland

CONSERVATIVE OR RESURFACING TOTAL HIP REPLACEMENT 636
William G. Mishler, M.D., and Thomas H. Mallory, M.D., Columbus

THE RELATIONSHIP BETWEEN UNEMPLOYMENT AND HEALTH 639
John H. Ackerman, M.D., M.P.H., and Mary F. Vaeth, M.D., M.S., Columbus

COMPARISON OF NATIONAL HEALTH SERVICE SYSTEMS. WHO HAS THE ANSWERS? 643
Robert S. Daniels, M.D., Cincinnati

HUMANISTIC MEDICINE: WILLIAM OSLER AND MEDICAL EDUCATION 647
Alvin E. Rodin, M.D., Dayton

CANCER EDUCATON SERIES: THE CASE FOR CONSERVATIVE MANAGEMENT OF CANCER 654
Frank Batley, M.B., Ch.B., Columbus

Special Articles

YOUR DOLLARS PLAY VITAL ROLE IN ASSISTING FUTURE PHYSICIANS 602
Robert D. Clinger, Columbus

SIX OHIOANS RECEIVE OUTSTANDING TEAM PHYSICIAN AWARDS 608

COMPUTERIZED AXIAL TOMOGRAPHY PAYMENT 610
D. Tom Dwyer, Columbus

BAKKE WOULD BE REJECTED AGAIN 615
American Medical News

NOTICE TO ALL OSMA MEMBERS 616

COUNTY SOCIETY ROSTER CHANGES 656

Features

Manuscript Guidelines 600
Colleagues in the News 605
Continuing Education Courses....612
Legislative Update — State.....651
Obituaries 656
New Members.....658
News 661
Journal Advertisers 664
Placement Service Ads.....665
Classified Ads.....667

COVER: This photograph won an Outstanding Entry Award in the 1978 Ohio State Medical Journal Photographic Exhibit. Dwight Tuuri, M.D., Dayton, captured the view during the late morning of October 1, 1977 in New Hampshire. He used a Realist camera and Kodacolor 2 ASA 100 film. (Lens: 50 mm, Aperture: f/5.6, Speed: 1/100 second) Dr. Tuuri entitled the scene "Prelude to Winter."

Copyright 1978. The Ohio State Medical Association. All material subject to this copyright may be photocopied for the noncommercial purpose of scientific or educational advancement.

Our 70th Year

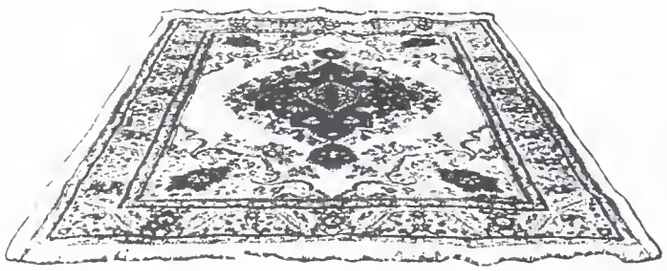
K. A. Menendian
has been known for
the finest quality and best values in
ORIENTAL RUGS.

We carry a complete selection of rugs from mats to mansion sizes. Over 1500 rugs in stock from Iran, India, China, Pakistan, Turkey, etc.

See over 4,000 samples in our newly remodeled carpet showroom from Karastan and other fine mills.

We specialize in Oriental rug cleaning and repairing.

K.A.Menendian
1090 West Fifth Avenue
294-3345



THERE IS A DIFFERENCE!

PREPARE FOR: NAT'L MEDICAL BDS
NAT'L DENT BDS FLEX VQE
ECFMG NAT'L NURSING BDS

Stanley H. KAPLAN
EDUCATIONAL CENTER

Flexible Programs and Hours

CLEVELAND AREA	COLUMBUS AREA	CINCINNATI AREA
14055 Cedar Rd.	1890 N.W. Blvd.	309 Ludlow Ave.
Cleveland, Ohio 44118	Columbus, Ohio 43212	Cincinnati, Ohio 45220
(216) 371-0035	(614) 486-9646	(513) 281-1818

Call Days, Evenings & Weekends

THE test preparation specialists since 1938

Ohio State Medical Journal Manuscript Guidelines

1. **EXCLUSIVE PUBLICATION.** Articles are accepted for publication with the understanding that they are contributed solely to this *Journal.* Permission for subsequent publication elsewhere must be obtained in writing from the Editor and from the Author.

2. **CORRESPONDENCE.** Address all correspondence relating to publication of scientific papers to: The Consulting Medical Editor, The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

3. **MANUSCRIPTS.** (a). Manuscripts should be submitted *in the original* on standard 22 × 28-cm (8½ × 11-inch) white typing paper.

(b). A copy of the manuscript should be retained by the Author.

(c). *The entire text including lists of REFERENCES should be TYPED DOUBLE OR TRIPLE SPACED with margins of at least one inch on all sides.*

(d). Tables, charts, and figures (illustrations) should be submitted separately from the text. They should be identified by number and by concise, descriptive titles. In the text, reference to them should be by number, eg, (Fig. 1).

4. **ILLUSTRATIONS.** (a). Illustrations (photographs, drawings, graphs, and tables) will be submitted to the printer for an estimate of cost. *The Journal* will assume $10 of this expense and the author will be billed by *The Journal* for the remainder.

(b). Each illustration should bear the figure number and the author's name on the back. When pertinent, the top of the photograph should be indicated. Do not clip, write on the back with a hard pencil, or otherwise mutilate the prints.

(c). Legends for the figures should be written on separate paper.

(d). The author must affirm that he has *written releases* on all photographs in which patients can be identified.

5. **ABSTRACTS.** *A short* (100-word maximum) abstract should be included with the article. It should cover the main points so that the reader may readily obtain the gist of the article.

6. **SUMMARIES.** The summary should be a concise restatement of the information given in the body of the article.

7. **REFERENCES.** (a). Lists of references should be at a minimum to conserve space and expense and be limited to those essential to the subject and to which actual reference is made in the text. The Editor reserves the right to reduce the number when necessary.

(b). References should be listed in the *order of their appearance in the text.*

(c). Authenticity and accuracy are the responsibilities of the Author.

(d). Each journal reference should include in this order: Author's last name and initials, title of article, name of journal (abbreviated in accordance with standard usage), volume number, inclusive page numbers, and year.

"2. Doe J, Roe RX: How to go about it. Ohio State M J 13:24-30, 1920"

Each textbook reference should include, in this order: Author's surname and initials, title of the book (capitalize all main words), edition, place of publication, name of the publisher, year of publication, volume, if more than one has been published, and page.

"5. Osler W: Modern Medicine, ed 3, Philadelphia, Lea & Febiger, 1927, vol 5, p 66."

8. **IDENTIFICATION OF PATIENTS.** Names, initials, hospital numbers, or any other identifiable labels, should *not* be used. It is preferable to identify patients for the purpose of publication by the use of numbers in series for the study being reported.

9. **METRICATION.** All measurements must be in metric units. English units should be given in parentheses following the metric in all cases where the measurement was originally done in English units.

10. **EDITING OF MANUSCRIPT.** Following acceptance of a manuscript for publication, it will be copy edited in conformance with the editorial standards of the American Medical Association, which *The Journal* follows. The copy-edited manuscript will be returned to the Senior Author for approval. At that time, he is asked to make all corrections and to have the manuscript retyped. Any changes, other than typographical errors, made by the Author after the manuscript is set in type will be billed to him at $1 per line.

11. **REPRINTS.** An order blank for reprints with a table covering cost will be sent with the galley proofs to the Senior Author. *The Journal* does not profit on reprint orders.

12. **EDITORIAL ASSISTANCE.** Miss Mary Lou Brady, *Journal* Editorial Assistant, stands ready to assist the Author in preparing his manuscript. For his own assistance, however, the Author is encouraged to consult standard texts on medical writing, such as the *Style Book and Editorial Manual,* prepared by the Scientific Publications Division, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

When **impotence** is due to androgenic deficiency.

Android® 5 mg. Buccal / 10 mg. Oral / 25 mg. Oral

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric/eunuchoidism, eunuchism/post-puberal cryptorchidism.



Write for new double-blind study reprints and samples.

BROWN **THE BROWN PHARMACEUTICAL CO., INC.**
2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

Your Dollars Play Vital Role in Assisting Future Physicians

Robert D. Clinger
OSMA Associate Executive Director

"Doctor, for each dollar you contribute to the American Medical Association Education and Research Foundation (AMA-ERF), another $12.50 will be put to work in loans by commercial banks to needy medical students and physicians-in-training," said Philip Hardymon, M.D., Columbus, Chairman of the Ohio AMA-ERF Committee.

Dr. Hardymon launched the 1978 AMA-ERF contribution campaign in Ohio by urging individual physicians and Auxiliary members to redouble their efforts in order to eliminate financial barriers for large numbers of outstanding medical students and physicians-in-training. He reminded OSMA members that this loan program for the benefit of future physicians is being conducted by a private sector of the economy without government subsidy.

"Our runaway inflation is placing tremendous financial burdens on these young people," said Dr. Hardymon. "For example, the tuition for Ohio residents at the University of Cincinnati College of Medicine in 1949 was $525 per year. Today, it has increased nearly fivefold to $2,400."

The AMA-ERF chairman also cited the Wright State University School of Medicine, where in 1976-1977, the freshman student expense budget (including scholastic and living expenses) was $7,635. In 1977-1978, the budget was increased by more than 10% to $8,425.

Contributions in 1977

According to Dr. Hardymon, AMA-ERF contributions by Ohio physicians in 1977 were considerably less than during the previous year. The 1977 total was $54,846.01, as compared with $66,509.37 in 1976 and $62,742.50 in 1975. (See Table 1.)

Dr. Hardymon cited the following:

* A total of 337 loans amounting to $744,500 were made to medical students and physicians-in-training in Ohio during the 1977 year. This represents a considerable increase over the 267 loans amounting to $375,000 in 1976.

Table 1. Ohio Contributions to AMA-ERF Student Loan Guarantee Program

Year	Total	Change from Previous Year
1978	?	Hopefully up!
1977	$54,846.01	down $11,663.36
1976	$66,509.37	up $ 3,766.87
1975	$62,742.50	up $21,067.38
1974	$41,675.12	down $ 7,430.72
1973	$49,105.84	up $ 6,891.19
1972	$42,214.65	down $ 7,876.23
1971	$50,090.88	up $ 87.88
1970	$50,003.00	- 0 -

* Since the loan program began in 1962, Ohio medical students and physicians-in-training have received a total of 2,973 loans amounting to $3,578,850. (See Table 2.)
* Total contributions to AMA-ERF throughout the nation during 1977 (distributed to medical schools in 1978) amounted to $1,150,697. Ohio ranked fourth in state contributions. (Table 3).
* During 1977, more than 5,000 medical students and physicians-in-training borrowed a total of $7.35 million to help meet their expenses. Since the program began in 1962, almost $85 million in loans have been arranged and guaranteed by the AMA-ERF.
* AMA-ERF grants to Ohio medical schools from 1977 contributions (distributed in 1978) were as follows:

University of Cincinnati College of Medicine	$14,213.38
Case Western Reserve School of Medicine	$ 7,984.39
Medical College of Ohio at Toledo	$ 5,478.01
The Ohio State University College of Medicine	$17,465.41
Northeastern Ohio Universities College of Medicine	$ 3,907.09
Wright State University School of Medicine	$ 5,797.73
Total	$54,846.01

Dr. Hardymon pointed out that accepted applicants become eligible for medical education loans of up to $1,500 a year. Additional applications may be approved each year so that a maximum of $10,000 can be borrowed over a seven-year period. Also, the borrower pays only the established interest rate during his training and has ten years after completion of training to repay the principal.

TABLE 2. AMA-ERF Loans to Ohio Medical Students, Physicians-in-Training*

Year	No. of Loans	Amount
1977	377	$477,500
1976	267	$375,000
1975	165	$252,600
1974	163	$213,100
1973	157	$202,500

*Figures unavailable for 1972, 1971 and 1970

TABLE 3. Top States in AMA-ERF Contributions During Calendar Year 1977

1.	Illinois	$137,102.13
2.	Tennessee	$ 78,386.27
3.	Pennsylvania	$ 59,310.28
**** 4.	*Ohio*	$ 54,846.01
5.	California	$ 47,704.10
6.	Florida	$ 45,737.30
7.	New York	$ 43,579.71
8.	Texas	$ 41,439.26
9.	Maryland	$ 39,440.61
10.	Virginia	$ 38,630.12

Contributions This Year

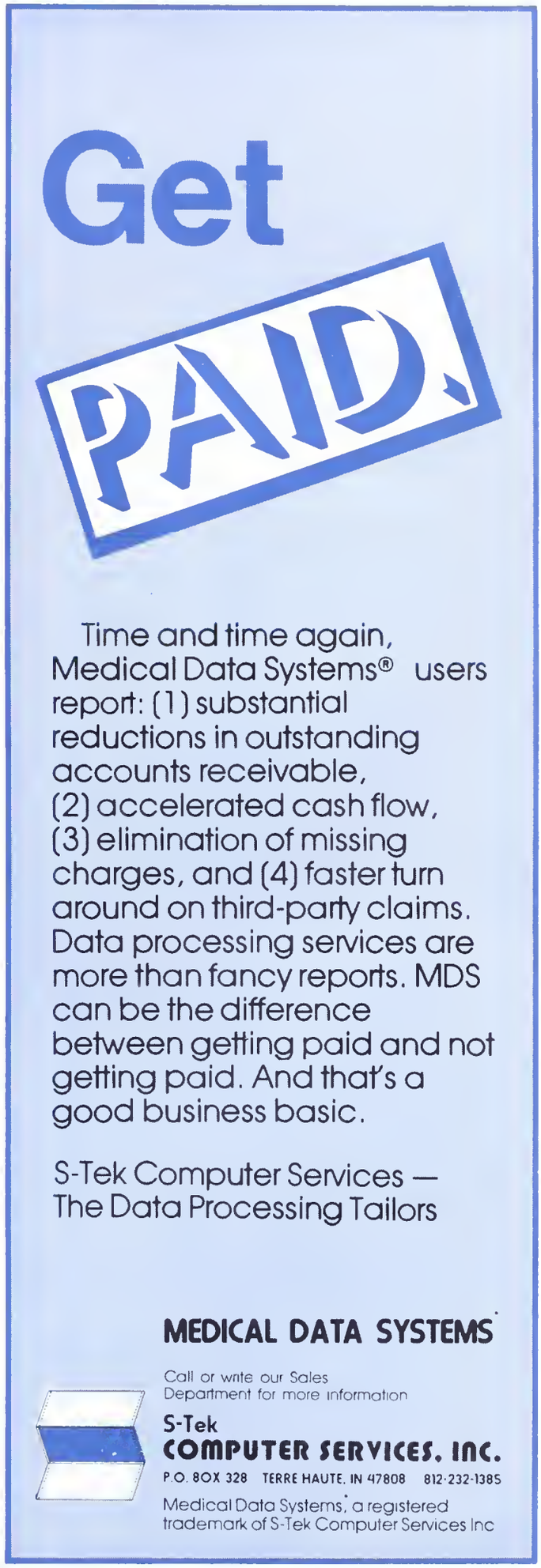
How do you contribute? Shortly after you receive this issue of *The Journal,* you will receive a letter from Dr. Hardymon and a special AMA-ERF return envelope. The inside of the envelope includes space for your choice of medical school to receive your contribution, choice of category for your contribution, and the amount of your contribution. The pre-addressed envelope containing your contribution goes directly to AMA-ERF headquarters in Chicago.

The AMA-ERF student loan program has been designed to alleviate the financial difficulties of medical students and to encourage career decisions in favor of medicine. AMA-ERF functions as a cosigning agency to make available through community banks relatively large sums of credit at a low rate of interest.

Realizing the importance of keeping medical education independent through private initiative and voluntary effort, Dr. Hardymon and members of the Ohio AMA-ERF Committee urge Ohio physicians to respond generously in this year's campaign.

You, Doctor, can become an important part of this program by contributing now. Where else can you buy so much for so little?

If you have any questions or need further information concerning the 1978 AMA-ERF campaign, do not hesitate to contact the OSMA Headquarters Office at 600 South High Street, Columbus, Ohio 43215, phone 614/228-6971. ☆☆☆



Angina freedom fighter...



Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Cardilate® (erythrityl tetranitrate)
INDICATIONS For the prophylaxis and long-term treatment of patients with frequent or recurrent anginal pain and reduced exercise tolerance associated with angina pectoris, rather than for the treatment of the acute attack of angina pectoris, since its onset is somewhat slower than that of nitroglycerin.

PRECAUTIONS As with other effective nitrites, some fall in blood pressure may occur with large doses.

Caution should be observed in administering the drug to patients with a history of recent cerebral hemorrhage, because of the vasodilation which occurs in the area. Although therapy permits more normal activity, the patient should not be allowed to misinterpret freedom from anginal attacks as a signal to drop all restrictions.

SIDE EFFECTS. No serious side effects have been reported. In sublingual therapy, a tingling sensation (like that of nitroglycerin) may sometimes be noted at the point of tablet contact with the mucous membrane. If objectionable, this may be mitigated by placing the tablet in the buccal pouch. As with nitroglycerin or other effective nitrates, temporary vascular headache may occur during the first few days of therapy. This can be controlled by temporary dosage reduction in order to allow adjustments of the cerebral hemodynamics to the initial marked cerebral vasodilation. These headaches usually disappear within one week of continuous therapy but may be minimized by the administration of analgesics.

Mild gastrointestinal disturbances occur occasionally with larger doses and may be controlled by reducing the dose temporarily.

DOSAGE: Therapy may be initiated with 10 mg sublingually prior to each anticipated physical or emotional stress and at bedtime for patients subject to nocturnal attacks. The dose may be increased or decreased as needed.

HOW SUPPLIED: 10 mg chewable scored tablets, bottle of 100. Also 5, 10 and 15 mg oral/sublingual scored tablets in bottles of 100. 10 mg oral/ sublingual scored tablets also supplied in bottle of 1,000.

Also available. Cardilate®-P (Erythrityl Tetranitrate with Phenobarbital)* Tablets (Scored).

(*Warning—may be habit-forming.)

1. Taken sublingually, Cardilate® (erythrityl tetranitrate) begins to work within 5 minutes, eliminating or reducing frequency and severity of anginal pain for up to two hours.
2. Fear of pain, a major deterrent to achieving acceptable (and desirable) levels of activity, including sex, may be allayed with Cardilate. Effective prophylaxis and improved exercise tolerance help toward normalizing the lives of anginal patients.

Cardilate®
(erythrityl tetranitrate)

Colleagues in the News

RALPH J. ALFIDI, M.D., Cleveland, has been appointed Professor and Chairman of Radiology at the Case Western Reserve University School of Medicine and Director of the Department of Radiology at University Hospitals of Cleveland. Head of the Department of Radiology at the Cleveland Clinic Foundation since 1968, he is certified by the American Board of Radiology and is a Fellow of the American College of Radiology. Formerly president of the Cleveland Radiological Society, he is president of the Society of Computed Body Tomography and a member of the Society of Cardiovascular Radiology and the Radiological Society of North America.

Dr. Alfidi will succeed **HYMER L. FRIEDELL, M.D.,** Professor of Radiology, who has headed the Department of Radiology at the School of Medicine and University Hospitals since 1946. Dr. Friedell will continue as professor of radiology and will be active as an officer of the National Council on Radiation Protection and Measurements.

GLEN F. AUKERMAN, M.D., Jackson Center, is the new President of the Ohio Academy of Family Physicians. Other officers are **ANDREAS S. AHBEL, M.D.,** Canton, president-elect; **TENNYSON WILLIAMS, M.D.,** Columbus, vice-president; **JOHN E. VERHOFF, M.D.,** Columbus, treasurer; **EUNICE R. CARTER, M.D.,** Cuyahoga Falls, speaker; **WILBURN H. WEDDINGTON, M.D.,** Columbus, vice speaker; **H. JUDSON REAMY, M.D.,** Dover, national delegate; and **DAVID A. BARR, M.D.,** Lima, national alternate delegate. Immediate past president is **KENNETH A. FREDERICK, M.D.,** Cincinnati.

Directors are **ARMIN R. FUHLBRIGGE, M.D.,** Toledo; **JANIS LAUVA, M.D.,** Wellsville; **DOUGLAS P. LONGENECKER, M.D.,** Jackson Center; **ROY MILLER, M.D.,** Medina; **DONALD B. TWIGGS, M.D.,** Logan; and **RONALD C. VAN BUREN, M.D.,** Columbus.

THOMAS E. FOX, M.D., Mason, was selected Family Physician of the Year for his dedication and service to his community and his diligent pursuit of the principles of family practice.

Three clinical instructors in the Department of Surgery at Wright State University School of Medicine have been certified by their respective specialty boards: **SOMA AVVA, M.D.,** Dayton, American Board of Plastic and Reconstructive Surgery; **HOMAYOUN MESGHALI, M.D.,** Dayton, American Board of Orthopedic Surgery; and **MARIOS PANAYIDES, M.D.,** Springfield, American Board of Surgery.

AL BATATA, M.D., Associate Professor of Pathology, was chosen one of two outstanding teachers of 1977-1978 by the Class of 1980 at Wright State University School of Medicine. He received the School of Medicine's "No Doze" award, symbolic of teaching excellence, and an honorarium at the annual convocation in September. Dr. Batata joined the School of Medicine in 1977 after six years at the Medical College of Wisconsin (Marquette).

WILLIAM H. BAY, M.D., and **JAMES CERILLI, M.D.,** Columbus, have received grants from the Kidney Foundation of Central Ohio, Inc. Dr. Bay is Director of the Renal Division of The Ohio State University Hospitals, and Dr. Cerilli is a transplant surgeon at that institution.

JOHN R. BELJAN, M.D., Dean of Wright State University School of Medicine, has been appointed the University's Vice President for Health Affairs. In this position, he will coordinate and integrate health-related professional activities for the school of Medicine, School of Professional Psychology, School of Allied Health Professions (if created), and a variety of support services. In addition, he will have principal responsibility for the planning and development of new health programs. For a transitional period of several years, Dr. Beljan also will continue his responsibilities as Dean.

Ohioans listed among the new members of the American College of Radiology are: **KAAREN N. BERGQUIST, M.D.,** Cleveland; **ALAN M. COHEN, M.D.,** Cleveland; **TERRY L. COHEN, M.D.,** Youngstown; **EDMUND P. HO, M.D.,** Toledo; **JAE M. KOH, M.D.,** Steubenville; **ROBERT R. LUKIN, M.D.,** Cincinnati; **BERNARD J. LEMIEUX, M.D.,** Maumee; **JAMES A. PATTERSON, M.D.,** Cleveland; and **DONG S. PARK, M.D.,** Tiffin.

(Colleagues continued on next page)

"Colleagues in the News" is sponsored by

Blue Shield

Ohio Medical Indemnity, Inc.

6740 North High Street, Worthington, Ohio 43085

(614) 438-3500

(PAID ADVERTISEMENT)

Colleagues in the News

(continued)

THOMAS B. BRALLIAR, M.D., Cleveland, has been elected President of the Cleveland Society of Anesthesiologists. Dr. Bralliar is a staff member of the Department of Anesthesiology of Huron Road Hospital.

T. L. COHEN, M.D., Youngstown, has passed the certifying examination of the American Board of Nuclear Medicine.

FRANK FALKNER, M.D., Yellow Springs, has been appointed to the United States-Japan Malnutrition Panel, United States Department of State, USA/Japan Program. Dr. Falkner is the Fels Professor of Pediatrics at Wright State University School of Medicine.

JOSEPH E. FISCHER, M.D., has been appointed Director of the Department of Surgery at the University of Cincinnati Medical Center. Dr. Fischer will also serve as the Christian R. Holmes Professor of Surgery at the University of Cincinnati College of Medicine. He comes to Cincinnati from his position as associate professor at Harvard Medical School and member of the staff of Massachusetts General Hospital.

MARTHA FRANZ, M.D., Dayton, has been named an honorary life trustee of the Cystic Fibrosis Foundation, Miami Valley Chapter. A member of the staff of The Children's Medical Center, she was recognized for her outstanding contributions and dedicated service to the chapter and to the cause of cystic fibrosis.

WILLIAM J. GERHARDT, M.D., Cincinnati, is the newly installed President of the University of Cincinnati Medical Alumnal Association (1978-1979). Dr. Gerhardt is Associate Clinical Professor of Pediatrics, University of Cincinnati College of Medicine, and president of the Medical and Dental Staff of Children's Hospital Medical Center, Cincinnati. Other officers include **BEN T. YAMAGUCHI, M.D.,** Assistant Clinical Professor of Pathology at the College of Medicine, president-elect; **STUART A. SAFDI, M.D.,** Cincinnati, executive secretary-treasurer; and **ROBERT E. KRONE, M.D.,** Cincinnati, Chairman of the Executive Council. **PAUL A. BUSAM, M.D.,** Cincinnati, is immediate past president.

SATYENDRA GUPTA, M.D., Centerville, and **THOMAS G. THORNTON, M.D.,** Dayton, have been elected to fellowship in the American College of Cardiology. Both Doctors Gupta and Thornton are assistant clinical professors in the Department of Medicine, Wright State University School of Medicine.

SHATTUCK HARTWELL, M.D., Cleveland, has been elected to the Board of Directors of the American Academy of Medical Directors. Dr. Shattuck is associated with the Cleveland Clinic.

RALPH E. HAYNES, M.D., has joined the staff of The Children's Medical Center, Dayton, as Director of Infectious Diseases. In addition, he has been named Professor and Vice Chairman, Department of Pediatrics, Wright State University School of Medicine. Prior to these appointments, Dr. Haynes was Professor of Pediatrics, The Ohio State University College of Medicine; and Director, Infectious Disease Division, Children's Hospital, Columbus. A Fellow of the American Academy of Pediatrics, he is a member of the American Society of Microbiology, Infectious Disease Society of America, American Pediatric Society, and Midwest Society for Pediatric Research.

ELIAS HUSNI, M.D., Cleveland has been named to the Board of Trustees of Huron Road Hospital. His term will expire in 1981. Dr. Husni is Associate Director of the Department of Surgery at the hospital.

CARL JELENKO III, M.D., has been appointed Professor in the Departments of Community Medicine and Surgery at Wright State University School of Medicine. He also will serve as Director of the Group in Emergency Medicine in the Department of Community Medicine. A charter member and immediate past president of the University Association for Emergency Medicine, Dr. Jelenko had served as Professor of Surgery at the Medical College of Georgia, Augusta.

JOHN C. JOHNSON, M.D., Columbus, has been elected President of the Central Ohio Radiological Society. The other officers are **S. CHRISTOPHER LEE, M.D.,** president-elect/treasurer; and **BROOKS H. SITTERLY, M.D.,** secretary, Marion.

RICHARD W. JUVANCIC, M.D., Youngstown, has assumed the position of Director of Family Practice Residency Training at the Youngstown Hospital Association. In addition, he will be coordinator of medical programs. Dr. Juvancic is preparing for the first family practice residents, who will arrive at the hospitals in July 1979, and for the first class of medical students from the Northeastern Ohio Universities College of Medicine in 1980. Dr. Juvancic comes to the position from duties as medical director for Youngstown Sheet and Tube Company's Youngstown District.

ROBERT S. KUNKEL, M.D., Cleveland has been elected Vice President of the American Association for the Study of Headache.

ELROY KURSH, M.D., Cleveland, has been named Visiting Professor of Urology, The Ohio State University. Dr. Kursh is Director of the Department of Medical Education at Huron Road Hospital.

HERMAN M. LUBENS, M.D., Dayton, has been elected Secretary-Treasurer of the Ohio Valley Allergy Society. Dr. Lubens is Associate Clinical Professor of Pediatrics at Wright State University School of Medicine.

CHARLES H. McGOWEN, M.D., Youngstown, recently published his second book entitled *Where There's Smoke*. . . . The text is a a treatise on the effects of smoking on the body. Dr. McGowen is a member of the clinical staff of the Youngstown Hospital Association.

RICHARD L. MEILING, M.D., Columbus, has been awarded Honorary Fellowship by the Greek Surgical Society. This award is in recognition of his consultation with faculties of medical facilities at Athens and Salonica over the past decade as they revised their medical curriculum for both undergraduate and graduate medical students. Dr. Meiling addressed the Society at its September meeting in Athens on the subject of American surgery and its role in the leadership of American medicine during the past two centuries.

GRANT MORROW III, M.D., has been appointed Chairman of the Department of Pediatrics at The Ohio State University and Medical Director of Children's Hospital, Columbus. In addition, he will serve as chief of the Department of Pediatrics at Children's Hospital. Dr. Morrow comes to Columbus from his position as professor of pediatrics at the University of Arizona School of Medicine, where he was also associate chairman and director of the Neonatal Biology Section of the Department of Pediatrics. He is a member of numerous organizations including the Society of Pediatric Research, American Pediatric Society, American Society for Clinical Nutrition, American Society of Human Genetics, American Academy of Pediatrics, and the American Medical Association.

SAMUEL E. PITNER, M.D., has been appointed Professor and Chairman of the Department of Neurology at Wright State University School of Medicine. Previously professor of neurology at the University of Tennessee College of Medicine, Dr. Pitner holds membership in numerous organizations including the American Academy of Neurology, American College of Physicians, and American Federation for Clinical Research.

WILLIAM K. RUNDELL, M.D., and **FRANK WELSH, M.D.,** have been elected to Fellowship in the American College of Surgeons. Both are Assistant Clinical Professors of Surgery at Wright State University School of Medicine, Dayton.

LOUIS SCHWAB, M.D., Dayton, has been elevated to the new and expanded role of Director of Medical Affairs at The Children's Medical Center. Previously Director of Medical Services at the institution, Dr. Schwab will direct the continuing process of updating and refining the long range plan for the Center as well as a new program in grants management.

ALAN SHAFER, M.D., Dayton, is the newly elected Chief of Staff of The Children's Medical Center, Dayton. Other officers include: **MARTHA FRANZ, M.D.,** Dayton, chief of staff-elect; **CHARLES GOODWIN, M.D.,** Dayton, secretary; **JAMES BRYANT, M.D.,** Dayton, chairman, Department of Medicine; **FRANCES UNGER, M.D., Dayton,** secretary, Department of Medicine; **HOMAYOUN MESGHALI, M.D.,** Dayton, chairman, Department of Surgery; and **ARTHUR GARDIKES, M.D.,** Dayton, secretary, Department of Surgery.

FRANK L. SHIVELY, M.D., Dayton, was named Teacher of the Year for 1977 by the Department of Surgery of Miami Valley Hospital. Dr. Shively is Clinical Professor of Surgery at Wright State University School of Medicine.

Dr. Morrow replaces **JOHN P. SHULTZ, M.D.,** who had been serving as Acting Medical Director, and **JUAN F. SOTOS, M.D.,** who had been the University's Acting Chairman of the Department of Pediatrics and Acting Chief of Pediatrics at Children's Hospital. Past president of the Children's Hospital Medical Staff, Dr. Shultz will return fulltime to his private practice; and Dr. Sotos will continue as Professor of Pediatrics and Chief of the Hospital's Section of Endocrinology and Metabolism.

A. CLAIR SIDDALL, M.D., Oberlin, has been elected president of the Ohio Academy of Medical History. The other officers are **CHESTER P. SWETT, M.D.,** Lancaster, vice president; and **PATSY A. GERSTNER, Ph.D.,** Cleveland, secretary-treasurer.

The Northwest Ohio Urological Association has awarded the first and only honorary membership in the Association. **ROSTYSLAW J. WASYLYSHYN, M.D.,** Toledo, president of the Association, made the presentation to Gary G. Hibbard, manager of Norwich-Easton Pharmaceutical's Professional Products District headquartered in Cleveland. Mr. Hibbard was chosen for membership to honor him ". . . for his personal contribution toward the foundation of the Northwest Ohio Urological Association and its continued growth." The other Association officers, **WILLIAM REACH SLOAN, M.D.,** Toledo, secretary, and **JAGADISH S. JHUNJHUNWALA, M.D.,** Toledo, treasurer, joined in congratulating him on behalf of the membership.

Six Ohioans Receive Outstanding Team Physician Awards

The Ohio State Medical Association has presented the 1978 Ohio Outstanding Team Physician Awards to six physicians. Sponsored by the Joint Advisory Committee on Sports Medicine of the OSMA and Ohio High School Athletic Association, in cooperation with the Ohio High School Football Coaches Association, the awards honor physicians who have given of their time to high school sports.

Selection criteria includes:

★ At least 20 years of service as a team physician for Ohio high schools;

★ Endorsement by the physician's county medical society, district councilor, or osteopathic academy; and

★ Endorsement by school officials, coaches, trainers, civic officials, parents, fans, or others in the physician's community.

Those Ohio physicians honored are:

JOHN C. BAUER, M.D.
Fostoria High School

A native of Defiance County, Dr. Bauer practices family medicine in Fostoria and spent a quarter century as team physician for Fostoria High School before his retirement from the position last year. He also is plant physician for the Atlas Crankshaft Corporation. A diplomate of the American Board of Family Practice, Dr. Bauer described his experience as a team physician: "I have developed extended friendships with the students, teachers and coaches. Through this, I have been able to stay young and still be an active sports participant while serving my community."

RICHARD B. BELT, M.D.
Mansfield Senior, Madison, and
Malabar High Schools

A former defensive end for the University of Oregon football team, Dr. Belt has practiced family medicine in Mansfield since 1957. In addition to his sideline duties, he is the organizer and supervisor of physical examinations for all athletes in the Mansfield City School system. He is a past president of the Richland County Medical Society and a past delegate to the OSMA House of Delegates.

WILLIAM M. EMERY, M.D.
Ashland High School

Dr. Emery is a strong proponent of comprehensive medical coverage and preventive health considerations for high school athletes. He played a major role in obtaining a full-time athletic trainer for Ashland High School. Dr. Emery supervises the school's athletic physical examinations, attends all varsity and junior varsity football games at home and away, and frequently visits practice sessions.

WILLIAM E. HUDSON, M.D.
New Philadelphia High School

Dr. Hudson's more than 25 years as New Philadelphia High School team physician earned him a 1977 Quaker Club award for medical service and general support to the school athletic program. A native of Nelsonville, he practiced family medicine for 44 years in New Philadelphia prior to his recent retirement. In 1968, he was presented the Outstanding Citizen Award of the Chamber of Commerce.

J. B. MARTIN, M.D.
St. Clairsville High School

Born and raised in Harrison County, Dr. Martin was St. Clairsville High School's team physician for 27 years before his retirement in 1977. He helped in recruiting other area physicians to assist with medical coverage of the school's athletic events, and served as president of the local board of education for more than 18 years. During the 52 years he practiced in St. Clairsville, Dr. Martin served two terms as president of the Belmont County Medical Society. In 1960, he was named "Citizen of the Year" by the St. Clairsville Board of Trade.

MICHAEL J. VUKSTA, M.D.
Ursuline High School

An active member of the Joint Advisory Committee on Sports Medicine of the OSMA and Ohio High School Athletic Association, Dr. Vuksta practices general surgery in Youngstown. He has served as Ursuline High School team physician for 16 years, and prior to that was team physician for five years with East High School in Youngstown. Dr. Vuksta was named a Fellow of the American College of Sports Medicine in 1962 and an advisory member of the National Athletic Trainers Association in 1965. During 1970-1972, he was a member of the Youngstown State University Athletic Advisory Committee. In 1975, the University presented him its first Award for Medical Contributions and Athletics.



LEFT TO RIGHT: Richard B. Belt, M.D., Mansfield; Michael J. Vuksta, M.D., Youngstown; J. B. Martin, M.D., St. Clairsville; John C. Bauer, M.D., Fostoria; William M. Emery, M.D., Ashland; and William E. Hudson, M.D., New Philadelphia. (Photograph courtesy *Canton Repository.)* ☆☆☆

Take your assets out of limbo to meet year-end expenses

holiday season • winter vacation • investment time

Hempel Financial Corporation has an office equipment sale/leaseback plan to provide you with *immediate funds* for a variety of uses and the benefit of *100% tax-deductible payments.* For complete details and information on our other financial programs, send for our brochure by returning the coupon today, or call toll-free **(800) 421-7177**; in California, call collect **(213) 475-0304**.

Name

Address

City State Zip

( )

Phone

HEMPEL FINANCIAL CORPORATION
10880 Wilshire Blvd., Los Angeles, CA 90024

Computerized Axial Tomography Payment

D. Tom Dwyer

Computerized axial tomography (CAT) is an outstanding addition to the modern medical armamentarium — ask any patient whose disorder has been quickly and painlessly identified by this sophisticated diagnostic tool. The advantages offered by CAT scanning in making diagnoses which previously required invasive procedures are evident; CAT is recognized as a major advance in medical technology.

And an expensive one.

Certainly no one would suggest that cost is— or ever should be— the primary consideration in the use of any medical technique or equipment. Always, the needs of patients will be the first and most heavily weighed factors used in selecting treatment or diagnostic modalities. Even more importantly, the cost of modern medicine's best and most advanced techniques should never prevent their full use by those who need them; medical necessity should be the deciding factor.

Medical necessity should be the final determinant in the application of CAT scans, from the standpoint of the physician who orders or performs the procedure and the insurer who pays for it. The use and payment for CAT scans and other medical innovations on a "medically necessary" basis has become a prerequisite to attaining a balance of quality and cost in health care services— a balance that must be maintained if the best in medical treatment is to remain available to all who need it.

Ohio Medical Indemnity's (OMI) concern for quality and cost is reflected in the fact that our contracts specifically state that payment will be made for services which are based on ". . . valid medical need and are appropriate and necessary under accepted standards of medical practice in the state of Ohio. . . ." Of course, this applies to CAT scans as well as other medical, surgical, and diagnostic procedures.

The principle of medical necessity really is not at issue; physicians and insurers agree that an "unnecessary" procedure would not be in the best interest of a patient and should not be performed. However, there is not equal agreement about the precise definition of "medical necessity."

Because defining that term as it applies to CAT scans is fundamental to CAT claims administration— and because we recognize that differences of opinion can arise among physicians and insurers about the specifics of such programs— we sought expert medical advice in establishing medical necessity criteria for claims involving CAT scans.

Indications for CAT Use Reviewed

An ad hoc advisory committee of physicians recommended by the Ohio State Radiological Society and the Ohio State Medical Association worked with OMI staff members in reviewing and clarifying a range of symptoms, diagnoses, and conditions of various areas of the body in which CAT scanning may be the procedure of choice.

These indications are broken down into two categories: those for which claims can normally be processed in a routine manner because they meet predetermined criteria, and those for which claims will be processed on a "by report" basis, (ie, when accompanied by documented evidence to support medical necessity in that specific instance).

A good illustration of the first category— those which can be routinely processed— is the CAT scan of the head (by far the most frequent CAT claim). The medical advisory committee assisted in establishing a set of specific and definitive criteria which are placed under broad headings: symptoms, physical findings, unresolved medical problems, and serial studies for documentation of response to treatment. A number of specific indications for CAT use, come under these broad headings.

The other categories are similarly extensive and specific in defining and identifying indications of medical necessity.

A CAT scan of the gallbladder is an illustration of a claim that will be processed on a "By Report" basis. When submitted without the required supporting evidence, claims in this category will be referred to professional relations personnel, who will contact the attending physician to obtain additional information.

Summary

We feel that the criteria established by the medical advisory committee is precise and specific enough to assess most CAT claims correctly and to the satisfaction of everyone involved. However, should a difference of opinion arise which cannot be resolved through normal channels, claims will be referred to the appropriate peer-review mechanism for advice.

We at OMI seek the support and cooperation of the physicians of Ohio in our CAT scan policy. We believe that, particularly in today's health care economy, careful insurance claims administration is essential to assure that our subscribers receive full value for their health care dollars— in both quality as well as cost. Our CAT scan policy exemplifieds that belief. ☆☆☆

Mr. Dwyer, Columbus, Director, Provider Affairs, Ohio Medical Indemnity, Inc.

easy to take







Keflex®
cephalexin

Lilly

Additional information available to the profession on request.
Eli Lilly and Company
Indianapolis, Indiana 46206

500738

THE OHIO STATE Medical Association Continuing Education Programs

Editor's Note: *The following are Category I courses offered in Ohio. Items for this listing come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in dates, places, or time occur too late to be corrected before publication. Physicians interested in a course are urged to contact the sponsoring organization to confirm the information listed. Sponsoring organizations may list Category I courses by contacting the OSMA Department of Continuing Medical Education or The Journal. Notification 90 days prior to the course would be appreciated. Due to space limitations, announcements may be published only once.* **See previous issues of The Journal for additional courses.**—*L.A.P.*

OSMA MEMBERS

The Ohio State Medical Board requests that you send your "Log of Continuing Medical Education Activities" to the Board *as soon as* you complete the 150 hours of CME required for reregistration of your medical license, January 1, 1980.

October 1978

OB/GYN SYMPOSIUM: October 18, Christ Hospital, Cincinnati; guest speaker: Eduard G. Friedrich, Jr., M.D.; 1 credit hour; no fee; contact: Educational Services Department, Christ Hospital, Cincinnati 45219, phone: 513/369-2300.

SYMPOSIUM ON BREAST CANCER: October 28, Bond Court Hotel, Cleveland; sponsor: Northeast Ohio Breast Cancer Group; 6 credit hours; fee: $30, includes lunch; contact: 216/421-7300, Ext. 205.

November 1978

PSYCHIATRY AND THE LAW: November 11, Christ Hospital, Cincinnati; coordinator: Glen M. Weaver, M.D.; 7 credit hours; fee: $40, special rate for students; contact: Educational Services Department, Christ Hospital, Cincinnati 45219, phone: 513/369-2300.

PRIMARY CARE/CLINICAL FOCUS ON AGING: November 11-12; Sheraton Downtown Hotel, Dayton; sponsor: Wright State University School of Medicine; cosponsor: Dayton Veterans Administration Center; 11 credit hours; fees vary; contact: Arlene Polster, Wright State University, Dept. PMCE, P.O. Box 927, Dayton 45401, phone: 513/372-7140.

ANTIBIOTICS IN OBSTETRICS AND GYNECOLOGY, TREATMENT OF SHOCK, D.I.C.: November 15, Marriott Inn, West 150th, Cleveland; guest speaker: William J. Ledger, M.D., Los Angeles; sponsor: Cleveland Society of Obstetricians and Gynecologists; 3 credit hours; contact: Pierre W. Martimbeau, M.D., Cleveland Clinic Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-6871.

GASTROENTEROLOGY: November 15-16; Cleveland Clinic Foundation, Cleveland; 12 credit hours; fee: $100, $50 students and physicians-in-training; contact: Phillip Gard, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

RUPERT B. TURNBULL SYMPOSIUM—INFLAMMATORY BOWEL DISEASE: November 17-18; Cleveland Clinic Foundation, Cleveland; 12 credit hours; fee: $150, $75 students and physicians-in-training; contact: Phillip Gard, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

ADVANCED CARDIAC LIFE SUPPORT WORKSHOP: November 18-19, Christ Hospital, Cincinnati; 16 hours credit; fee: $140; contact: Educational Services Department, Christ Hospital, Cincinnati 45219, phone: 513/369-2300.

WORKSHOP ON ENDOMETRIAL CANCER: November 29, Marriott Inn-Beachwood, I-271 and Chagrin; sponsor: Northeast Ohio Gynecologic Cancer Group; 5 credit hours pending; fee: $30, includes lunch; contact: 216/421-7300, Ext. 205.



WINDSOR HOSPITAL

A NONPROFIT CORPORATION

— ESTABLISHED 1898 —

Chagrin Falls, Ohio

247 - 5300

A hospital for the treatment of Psychiatric Disorders

High on a Hill-Top, Overlooking Beautiful Chagrin River Valley.

Accredited by Joint Commission on Accreditation of Hospitals.

Booklet available on request.

FRIEDRICH A. LINGL, M.D. Medical Director

GUY H. WILLIAMS, JR., M.D. Medical Director Emeritus

HERBERT A. SIHLER Jr. President

MEMBER: American Hospital Association—National Association of Private Psychiatric Hospitals

This asthmatic isn't worried about his next breath...

he's active he's effectively maintained on

QUIBRON®

Each capsule or tablespoon (15 ml) elixir contains theophylline (anhydrous) 150 mg and glyceryl guaiacolate (guaifenesin) 90 mg. Elixir: alcohol 15%



- theophylline for effective around-the-clock bronchodilator therapy
- 100% free theophylline

Indications: For the symptomatic relief of bronchospastic conditions such as bronchial asthma, chronic bronchitis, and pulmonary emphysema.

Warnings: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other compounds containing xanthine derivatives concurrently.

Precautions: Use with caution in patients with cardiac disease, hepatic or renal impairment. Concurrent administration with certain antibiotics, i.e. clindamycin, erythromycin, troleandomycin, may result in higher serum levels of theophylline. Plasma prothrombin and factor V may increase, but any clinical effect is likely to be small. Metabolites of guaifenesin may contribute to increased urinary 5-hydroxyindoleacetic acid readings, when determined with nitrosonaphtol reagent. Safe use in pregnancy has not been established. Use in case of pregnancy only when clearly needed.

Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 μg/ml.

How Supplied: Capsules in bottles of 100 and 1000 and unit-dose packs of 100. Elixir in bottles of 1 pint and 1 gallon.

See package insert for complete prescribing information.

Mead Johnson PHARMACEUTICAL DIVISION

©1978 Mead Johnson & Company • Evansville, Indiana 47721 U.S.A. MJL 8 4294R

The Great Laxative Escape



COLACE®

dioctyl sodium sulfosuccinate

Colace means escape—from laxative stimulation, from laxative harshness, from laxative habit. Colace gently helps soften stools for easy, painless, unstrained elimination. It's the great laxative escape, from infancy to old age. Available in 100 and 50 mg. capsules. Syrup or liquid.

Mead Johnson
PHARMACEUTICAL DIVISION

©1978 Mead Johnson & Company • Evansville, Indiana 47721 U.S.A. J578-1

American Medical News Reports

Bakke Would Be Rejected Again

Charles Lowrey, M.D., the Chairman of the Admissions Committee at the University of California-Davis that turned down Allan Bakke, says he would do it again.

In a report in the Sept. 15 issue of *American Medical News,* the American Medical Association's newspaper for physicians, Dr. Lowry says:

"Sure, I'd do it again in a minute. On the other hand, I don't feel very badly that Bakke will by court order be starting school here next month."

In having to decide between solidly qualified candidates like Bakke and minority applicants, "the Admissions Committee was caught between the devil and the deep blue sea," he told AM News National Affairs Editor Dennis Breo.

"I feel a lot of compassion for someone like Bakke, who is obviously qualified to go to medical school. I think of maybe having one of my own children caught in the same situation. But, at the same time, I believe strongly in programs to recruit minority physicians. How are we ever going to make amends to our minorities for the long and bitter bias against them unless we start somewhere?"

Dr. Lowrey feels Bakke happened to be the wrong man at the wrong time applying to the wrong place—and, most importantly, at the wrong age. He cites two factors that he says worked against Bakke's admission:

First, he was too old. Although we don't have an age limit, we do, because of the scarcity of physicians, like to get qualified applicants as young as possible to assure maximum duration of practice. We don't use age as a cutoff, but tend to look a lot harder at anyone past age 28 or 30.

Second, as a graduate engineer, Bakke already had a profession. Plus a master's degree. Why not give a chance to the qualified black or chicano who has never before had an opportunity to be a professional?

We thought of our minority recruitment program in terms of a "goal" rather than a "quota," but we did reserve 16 places each year for applicants from minority groups, basically blacks and chicanos. In this part of California, at least, we don't think of Orientals as a minority.

It was this "slotting" of admissions spaces for minority applicants, Dr. Lowrey says, that enabled Bakke to sue successfully. It is likely, the physician adds, that without this "easy target," Bakke would neither have been admitted to medical school on his merits nor been able to press a reverse-bias complaint.

Dr. Lowrey said:

I think he decided to sue us because he thought this is where he had the best chance of success. You know Bakke applied to 13 medical schools, including eight of the nine in California (all but Loma Linda U., which is denominational), and was not admitted to any. In fact, he never made the "alternate list" at any, including Davis. Stanford, I know, anticipated a suit from him.

When he applied for the 1973 school year, Bakke's ranking by committee interviewers was 468 of a possible 500. No one with a score of 468 or lower was either admitted or put on the alternate list, under our regular admissions program (applicants to the special admissions program for minorities were handled separately and had dramatically lower scores). To fill our class of 84 regular admittees, we sent out about 150 letters of acceptance. And about 20 applicants were put on the alternate list. All of these people had scores higher than Bakke's.

Bakke wrote me a letter saying that he strongly disagreed with our special admissions program. He had previously written to the dean of admissions back in 1971— when he was 30— asking how an applicant of 30 might be received. He was told then that there is no age cutoff but that we do look harder at applicants 30 or older.

When Bakke then applied for the 1974 school year, I was one of his six admissions committee interviewers. I rated him at 86, the lowest of his evaluations (Bakke was rated at 549 of a possible 600 in his 1974 application.)

How would Dr. Lowrey have rated a 25-year-old Bakke?

I might have given him a 92 or a 93 and the other interviewers correspondingly higher. I think the second time around he came much closer to being admitted and had he been younger this might have tipped the scales in his favor.

Frankly, though, when I interview an applicant for medical school, I'm looking for that spark of brilliance, of inventiveness, of original thought that indicates tremendous potential. Bakke did not strike me that way.

However, I will be the first to admit that a 45-minute interview is not a foolproof method to assess a person's potential.

And we spent about a third of the time discussing our special program. Bakke felt strongly that admissions to medical school should not be discriminating in any way. He was not sympathetic in any way to our efforts to train minority physicians. I found his attitude limited. He had no alternate plan to attract more minority MDs.

For the 1974 school year, Dr. Lowrey notes, Bakke again was neither admitted to Davis nor put on the alternate list. "This was on the basis of his scores compared to the other applicants to the regular program," he says. "Bakke was also neither admitted nor put on the alternate list at the other schools to which he applied."

Bakke, of course, sued for admission and the rest is legal history.

"I expected his suit," Dr. Lowrey says. "He was a Marine, wasn't he?"

Given his age handicap, Dr. Lowrey says, Bakke was lucky to have had the strict slotting system to shoot at legally. "As far as I'm concerned," Dr. Lowrey says, "programs such as the one at Harvard, which the Supreme Court cited, are just like ours. It's just a matter of semantics. But the setting-aside of specific spaces enabled Bakke to win."

Dr. Lowrey has two hopes for the future: "I hope we can maintain our momentum on minority recruitment, and I hope that Allan Bakke is accepted like any other student this fall." ☆☆☆

NOTICE TO ALL OSMA MEMBERS

Biographical Survey:

A biographical form was sent to you with the September *OSMAgram*. The purpose of this survey is to build an accurate data base on the OSMA computer for each Association member. The computer file will be used for multiple purposes including addressing of all publications, dues billing for county societies requesting this service, membership record keeping, AMA dues certification, licensure record, and continuing medical education planning and record keeping. (Medical Education Number is listed above name on OSMA membership card.)

If you have not received your copy of the biographical form, call Mrs. Katherine Wisse, OSMA Comptroller, at the Headquarters Office, phone: 614/228-6971.

Please return the form to the OSMA office NOW.

Membership Dues:

Your membership in the Ohio State Medical Association and the American Medical Association, including subscriptions to *The Ohio State Medical Journal* and *The Journal of the AMA,* will expire on December 31, 1978. Here is how to renew:

Mail your dues promptly to the secretary-treasurer of your county society or to the OSMA if your county society uses the OSMA dues billing service.

★ Active Member	OSMA membership dues are $170; AMA dues are $250. (AMA dues $125 for physicians in first year of practice.) Contact the secretary-treasurer of your local society for correct amount of county dues.
★ Member-in-Training	OSMA dues are $20; AMA dues are $35. Membership entitles physician to all privileges including the right to vote and to hold office.
★ Student Member	OSMA dues are $15; AMA dues are $15. Full-time students enrolled in medical schools approved by the AMA are eligible.

OSMA members will receive *The Ohio State Medical Journal,* the *OSMAgram,* and *Synergy* without extra cost as part of the services and benefits of membership. AMA dues-paying members will receive a year's subscription to *The Journal of the AMA* and the *American Medical News.*

Any member who becomes eligible for exemption from dues because of retirement or disability should notify the secretary-treasurer of his county medical society to effect this status change.

For Futher Membership Information:

Contact— Mrs. Katherine E. Wisse, OSMA Comptroller, 600 S. High Street, Columbus, Ohio 43205, telephone: 614/228-6971.

THE OHIO STATE Medical Association Clinical and Scientific

Management of Retinal Detachments

William H. Havener, M.D.

Modern monogement of retinol detochments no longer requires prolonged hospitalizotion ond disobility. Most potients require no more thon three doys of hospitolizotion ond moy return to normol activity within two to three weeks. General information, including pre- ond postoperotive monogement, is summorized in this orticle.

A REVIEW OF THE DETAILS of managing patients with retinal detachments is timely because the ordeal of hospitalization and convalescence has been greatly simplified and because previously inoperable, massive vitreous retraction cases often can be restored to partial sight. Also, periodic review of the management of a relatively rare condition refreshes one's memory of the appropriate steps in patient evaluation and care.

Our goals are the earliest possible detection of new retinal holes or detachments, safe transportation, prompt surgical correction, and the shortest effective convalescence period.

Detection of Holes

There is no substitute for indirect ophthalmoscopic examination, with the pupil dilated and the patient reclining so that the ophthalmoscopist can move 360° around the eye comfortably. Reasonably adequate examination of an uncomplicated retinal periphery can be achieved in this manner within no more than a minute per eye. Do *not* examine the patient seated erect in an examining chair. The entire periphery cannot be scanned in such a position.

The "five-second test" will help in the selection of eyes at greatly increased risk of having retinal holes. Examine the deep vitreous for pigment cells or erythrocytes, using a fairly broad slit-lamp beam and high magnification. This test is of no value in aphakic eyes or in similar conditions in which pigment and red cells are routinely expected to be in the vitreous. Normally, no intact eye will contain such cells in the vitreous, hence, their detection indicates disruption of membranes or vessel walls. The pathologic cells will be found mainly in the deep vitreous, not anteriorly, so a well-dilated pupil is a prerequisite for their detection. Be sure to have a narrow angle between the axes of illumination and observation, high magnification, and a fairly broad moving slit beam. Such evaluation of the deep vitreous structure should be part of your biomicroscopic routine. If a posterior vitreous separation is present, most cells originating from a retinal tear will be behind the posterior vitreous face.

A three-mirror, contact lens examination of the peripheral retina requires considerably more time than the preceding two tests. As it entails moderate annoyance and discomfort, it is only indicated when the ophthalmologist has a very high degree of suspicion that a retinal hole may be present, eg, if cells are found in the deep vitreous.

The typical history of sudden onset of hundreds of floating spots identifies the need for peripheral retinal examination. The punctate or "soot-like" spot is especially characteristic of individual cellular floaters, whereas an ordinary, uncomplicated, posterior vitreous separation will evidence itself with linear or net-like floaters. Statistically, very few posterior vitreous separations are associated with formation of new retinal holes, but without fundus examination, I cannot reliably establish the absence of holes by history alone.

Because of the greater significance of retinal holes in eyes with degenerative vitreoretinal changes, indirect ophthalmoscopy of the peripheral retina should be part of the routine examination of such eyes. Some examples are:

1. Careful peripheral ophthalmoscopy is appropriate in aphakic patients at the first postoperative examination (one week after surgery) and again at the three-month and annual check-ups.

2. In myopes, at least at the first examination and annually if vitreoretinal traction changes (lattices) or myopic atrophic changes are recognizable, particularly in patients with myopia of prematurity (minimal retrolental fibroplasia) who are predisposed to retinal detachment during the second and third decade of life.

3. In patients with familial retinal detachment (Mar-

Dr. Havener, Columbus, Professor and Chairman, Department of Ophthalmology, The Ohio State University College of Medicine.

Submitted May 15, 1978.

fan's syndrome, Wagner's vitreoretinal degeneration) following contusions sufficiently severe to cause intraocular hemorrhage, and particularly in patients with poorly controlled glaucoma who suddenly develop a soft eye.

4. Most especially, *both* eyes of a patient who has previously suffered a spontaneous, rhegmatogenous retinal detachment should be examined carefully at every routine annual visit. Be particularly suspicious of the ends and back edges of lattice-degeneration areas because this is a high-risk area for formation of new holes.

Management of Retinal Holes

As many as 5% of patients may have retinal holes, most of which will not cause retinal detachment and do not require surgery. Unfortunately, we cannot be certain of the validity of our recommendations for or against cryotherapy in an individual case, nor do retinal surgeons agree in their opinions on it.

I recommend urgent surgery, with transportation to the hospital in a gravity-dependent position for the hole (lying left-side-down for a one o'clock hole) if the patient has a recent (less than one week) symptomatic onset (sudden vitreous floaters) of a horseshoe tear as large as one-half disc diameter, located in the upper two-thirds of the periphery, associate with an easily recognized amount of vitreous liquefaction (posterior vitreous face visible on upgaze), with no surrounding pigmentation. (A pigment ring indicates that the hole is old). Reading should be prohibited. The larger such a tear, the more likely a subsequent detachment. Presence of a rim of already-detaching retina adjacent to the fresh tear almost guarantees progressive detachment and requires immediate gravity-dependent positioning.

Recent, symptomatic, smaller tears, round holes free of vitreous traction, and inferior tears are less likely to cause rapidly developing detachment. Hence, they may be treated at the patient's near convenience and do not require restricted activity before treatment. Although I am certain many such faults will never cause retinal detachment, I believe the risk is sufficient to justify the recommendation for cryotherapy within several weeks to a month. If the patient has previously suffered a retinal detachment in the same or fellow eye, I would recommend prompt hospitalization and treatment.

Gravity-dependent positioning of the hole and avoidance of reading will arrest progression of retinal detachment or transformation of a hole into a detachment. Binocular patching is unpleasant, if not terrifying, and rarely is necessary. An uncooperative patient may be forced to limit his unauthorized activity by binocular occlusion, but a really uncooperative one will just remove the eyepads.

Limitation of activity and gravity-dependent positioning is indicated to prevent critical progression of a detachment. By "critical progression," I mean a change sufficient to alter the management or prognosis. For example, the distinction between simple cryotherapy and cryotherapy with explant depends on the presence of recognizable detachment surrounding the tear. The transition between local explant and circling procedure depends upon height of the detachment. The prognosis for good central acuity depends upon sparing of the macula by the detachment. Limited activity is especially urgent if the detachment is approaching the macula. A safe distance (so many disc diameters) from the macula cannot be specified because it depends upon the rate of progression of the detachment. A history of rapidly advancing, inferior field loss would evidence rapid progression of the detachment, whereas incidental discovery of an asymptomatic inferior detachment evidences very slow progression. After the macula is detached, there is no reason for limited activity since damaged central vision already has been incurred. Use of a bedpan is a very unpleasant requirement and should be ordered sparingly. I allow bathroom privileges unless the macula is in imminent danger, a giant tear (over 90°) is developing, the vitreous is almost completely fluid, or a large horseshoe tear is just beginning to detach.

Asymptomatic retinal tears discovered on routine examination usually do not require cryotherapy, especially if a surrounding ring of pigment indicates that they persisted unchanged for at least a period of months. Please observe the distinction that a spontaneously developing pigment ring does not seal the hole as would a cryotherapy bond. Because of spontaneous arrest of progression of the detachment, a pigment deposit forms at the junction between attached and detached retina. The pigmentation occurs *after* the detachment stops progressing and is *not* the cause of the arrested progression. Many retinal detachments are due to pigment-encircled holes. However, very few pigmented holes (probably less than 1%) cause detachments. If a retinal detachment subsequently develops in an eye with a pigmented hole, a brand new hole elsewhere in the retina is the most likely cause. I would use cryotherapy on a pigmented retinal hole before cataract extraction or at the time of surgery for retinal detachment caused by another hole in the same eye. Other than in these instances, the value of treatment is doubtful. I do not treat lattice degeneration prophylactically, except as part of detachment surgery upon the involved eye.

Cryotherapy Management

Local anesthesia with topical proparacaine and subconjunctival injection adjacent to the hole is adequate. Retrobulbar anesthesia and lid akinesia are unnecessary. An equatorial conjunctival buttonhole large enough to admit the cryoprobe will permit easier manipulation and cause less postoperative reaction than transconjunctival freezing. The frozen area should extend approximately one disc diameter beyond the limits of the retinal tear. Do not attempt to seal a limited detachment with cryotherapy alone because a substantial failure percentage will result. Moderate postoperative pain will appear when the anesthetic wears off and may require analgesia of the level of one or two aspirins.

Freezing is known to disrupt the pigment epithelium and undoubtedly weakens the normal retinal attachment. I advocate one day of postoperative bed rest with the hole dependent if the threat of the hole appears so great as to

warrant emergency treatment. (Although the threat of detachment is not great, I have seen occasional instances of retinal detachment occur shortly after cryotherapy of a hole.) Depending on the seriousness of the hole, the patient is discharged from the hospital on the first or second postoperative day and told to observe limited activity for ten days. Thereafter, he may undertake full normal activity with *no restrictions*.

As can be seen with the indirect ophthalmoscope or the biomicroscope, eye movements cause violent whipping shifts of the partially detached vitreous. Since reading causes such movements, I prohibit it for ten days. Binocular patching probably is not helpful, nor are pinhole glasses. (We never use pinhole glasses and rarely use binocular patching.) Rapid eye movements (REM) during sleep cannot be prevented by patching. They exceed the violence in such normal eye movements as eating or walking.

The eye should be reevaluated ten days following cryotherapy of a flat retinal hole. A complete pigment ring should encircle the hole, no retinal detachment should be present, and no new holes observed elsewhere. If these criteria are met, the patient should resume full activity immediately, but should return if any new, unexpected symptoms appear. He should be urged to return promptly if many new floaters appear or if a progressive field defect develops. Assure the patient that the original floaters will not disappear until several months after treatment and that the cryotherapy will release new pigment into the vitreous if the hole is large. Neither of these floaters indicates trouble.

Discomfort following prophylactic cryotherapy of a flat retinal hole is very minimal and should be tolerated by patients with virtually any physical infirmity.

Surgery for Retinal Detachment

The retinal detachment operations we perform last about an hour. Unexpected problems may extend the length of surgery greatly, and patients tend to move about and complain with prolonged local anesthesia. Therefore, we prefer general anesthesia for most cases, the preoperative work-up to include chest x-ray, electrocardiogram, and electrolyte intake. Most cancellations of scheduled surgery by the anesthesiologist are because of the patient's low potassium level caused by antihypertensive therapy. Barring any contraindication, we usually admit all patients with retinal detachment immediately (unless they do not need emergency care) and operate the next day.

Technical details of the surgery are adequately documented in the reference. In general, we believe a circling fascia lata procedure is the most satisfactory choice for most cases. It is adaptable to almost all contingencies, is highly effective, and has almost no early complications. There are no late complications (migration, erosion, irritation, allergy, intolerance, or late infection) as are commonly encountered with silicone implants. Since I introduced the use of donor fascia lata in 1962, we have used the procedure in more than 10,000 operations; this certainly is adequate documentation of its characteristics. The oldest fascial tissue we have observed was in a reoperation 13 years after the original procedure. The donor fascia was still physically strong, appeared virtually unchanged in characteristics and appearance from a fresh piece of fascia, and had caused no scleral erosion or damage of any sort. The amount of scarring surrounding donor fascia is the same as would be seen surrounding a rectus tendon following strabismus surgery and is induced by the trauma of surgery, not by tissue reactivity or intolerance.

Postoperative Restrictions

The postoperative restrictions are essentially those required by the general anesthetic. No bed confinement is required except for the occasional patient with a giant tear or an unusually liquid vitreous. When the patient feels able, he may be fully ambulatory, stooping over to put on shoes, up to the bathroom, able to comb and wash his hair, brush his teeth, climb stairs, and carry his suitcase home. I advise against reading for ten days; this is mainly because of the discomfort of eye movements. In the fascia technique, the retina is solidly trapped between the buckle and the vitreous and is most unlikely to be displaced by movement.

Older patients do not tolerate general anesthesia well. Most patients do not feel well enough to go home before the second postoperative day although a few return home the day after surgery. They fatigue easily for three to six weeks and are unable to return to normal activity any earlier. I consider the anesthetic the limiting factor in the patient's ability to undergo detachment surgery. When surgery is again necessary, either to the same eye or to the other eye, more patients express concern and hesitancy about the anesthetic than about the surgery.

The patient must be advised that full visual recovery requires at least three months, at which time a spectacle change usually is necessary. If the macula has been detached for less than two weeks, vision of 20/40 or better is quite common. Patients with macular detachments of longer than two weeks rarely recover vision better than 20/40. Distortions and displacements of vision must be expected after macular detachment. If unrealistic expectations of perfect recovery of vision are encouraged before surgery, the patient will be unhappy and disappointed. However, most patients will attain good final vision if the macula is unaffected.

Tissue swelling and soreness may cause some limitation of movement and diplopia even though no muscles are operated. This will disappear within several weeks in most cases. The most persistent problems with diplopia occur when the recovery of vision is too poor to aid fusion. Such blurred, displaced images can be dreadfully annoying, and are not subject to remedy by muscle surgery.

Because the outer segments of the rods and cones die when detached from their choriocapillaris nutrition, maximum visual recovery is not attained until outer segment regeneration occurs after two to three months. Also, the vitreous usually is blurred at first by cellular debris from

the original hemorrhage and from the cryotherapy. Vision of only 20/200 one month following surgery does not preclude 20/40 vision by three months.

Postoperative Medication

Atropine 1% is prescribed once daily for two weeks and is almost always discontinued then. Some eyes maintain a persistent flare, both before and after surgery. Posterior synechiae will develop in these cases, even if no surgery is performed; continued use of atropine is important. Pilocarpine and the other parasympathomimetic drugs break down the blood-aqueous barrier and promote inflammation. I advise control of glaucoma with epinephrine and acetazolamide until the surgical inflammation has disappeared, at which time the patient may resume his preoperative miotic therapy.

Miotics have been blamed for causing retinal detachment. Indeed, there is a statistical relationship between the use of miotics and retinal detachment, just as there is a relationship between cataract, macular degeneration, glaucoma, retinal detachment, corneal dystrophy, aphakia, and loss of hair. Old, tired eyes are subject to multiple problems that do not necessarily cause each other. I do not believe that any miotics cause retinal detachment. I recommend that they be used as necessary in the treatment of glaucoma except during the several-week period of postoperative breakdown of the blood-aqueous barrier.

Corticosteroids are grossly overused in postoperative eyes. Controlled studies indicate no significant difference in the course of postoperative inflammation whether or not corticosteroids are used. I very rarely prescribe them following surgery. Similarly, our patients seldom take antibiotics home with them. (Application of antibiotic ointment at the close of surgery does reduce the amount of sticky crusting adherent to the eyelashes at the first dressing. Perhaps the ointment base alone would do the same.)

Massive Vitreous Retraction

The cause of massive vitreous retraction (MVR) is not well understood. Invasion of the eye with pigment cells has been implicated, suggesting that these cells enter via the tear, proliferate upon the inner surface of the retina, and then shrink. Clinically, I perceive a continuum between the preoperative (indeed, the pre-detachment) eye and the final end stages of MVR. One can suspect most cases of future MVR even before surgery. Obviously, this excludes the trauma of the detachment operation from being the causative factor. I imagine that inflammatory damage within the vitreous is the cause. By far, the majority of cases of MVR occur in aphakic eyes, many of which have experienced a stormy postoperative course. The condition is recognized generally as precluding good visual results, even if anatomic reattachment is possible. This is due to macular pucker distortions caused by shrinking membranes adherent to the macula.

MVR differs from retrolental fibroplasia in that the vitreous never shrinks to nothing. The key to its correction is reduction of the volume of the globe to that of the remaining solid vitreous. By definition, then, there will be no subretinal fluid and no detachment. This requires a severe constriction of the equator with a silicone sponge circle so that the eye literally resembles a wasp-waisted watermelon. Despite the MVR, about 80% of retinas can be reattached. Vision usually is less than 20/200 because of the macular damage, but a few cases with minimal central pucker do achieve better acuity.

This is my least favorite operative procedure because about one-third of the patients have very severe pain for a month or more, the eye is cosmetically small, and vision is always disappointing. Nevertheless, 20/200 vision is much better than no vision, and most patients are grateful for whatever vision can be restored.

Length of hospitalization is the same as for regular detachment surgery. Convalescence is slower, and sedatives and analgesics often are necessary for weeks.

Anterior Chamber Lenses

Aphakic holes are characteristically harder to see because they are small and located in the far periphery. Presence of a plastic lens contributes to this difficulty because of the optical distortion of the peripheral lens. Also, these eyes have at least their share of MVR.

I believe the prognosis of aphakic detachments with intraocular lenses is appreciably poorer than for ordinary aphakic detachments, but we have not had enough cases yet for a significant comparison.

As a surgeon who performs detachment surgery, if I had suffered a retinal detachment in one eye and were about to have cataract surgery in the other eye, I would prefer intracapsular extraction with a one-hour-sector iridectomy and multiple 10-0 nylon sutures. I do not think the support of the posterior capsule or of the IOL prevents detachment. The sector iridectomy enhances inspection of the upper periphery. The multiple nylon sutures will permit detachment surgery at any time following cataract surgery — even during the first week, if necessary.

Summary

The decision as to whether a patient can, or should, undergo surgery for retinal detachment depends largely upon his ability to withstand general anesthesia. If his physical condition is not strong enough for such anesthesia, his general prognosis probably would not justify the surgery.

The other significant factor is the expected visual return. Prolonged (months) detachment of the macula or macular crumpling precludes central acuity. Since 10% of patients will suffer detachment in the other eye, it usually is desirable to obtain partial vision. This can be achieved now in most patients, even in those suffering from massive vitreous retraction.

Reference

Havener WH, Gloeckner S: *Atlas of Diagnostic Techniques and Treatment of Retinal Detachment*. St. Louis, C V Mosby Co, 1967. ☆☆☆



J. HARRY MOSHER, CLU
VICE PRESIDENT

CONSULT WITH . . .
The Professionals!

These T&S representatives provide professional service throughout the state to members of The Ohio State Medical Association.

Feel free to call the Turner and Shepard office nearest you for insurance counseling, advice, or information on the Association-sponsored coverages which we administer.

- **Group Term Life Plan**
- **Disability Income Protection Plan**
  (co-sponsored with many local medical societies)



JIM LEWIS
COLUMBUS



JOE VOLZ
CINCINNATI

TURNER & SHEPARD, inc.

AFFILIATED WITH ALEXANDER & ALEXANDER, INC.

Columbus, Ohio 43215	17 South High Street	Phone (614) 228-6115
Akron, Ohio 44313	3090 West Market Street	Phone (216) 434-5000
Cincinnati, Ohio 45241	4015 Executive Park Drive	Phone (513) 563-4220
Cleveland, Ohio 44134	1440 Snow Road	Phone (216) 741-4466
Toledo, Ohio 43606	3450 West Central Avenue	Phone (419) 535-0616



SHERRY RAMSEY
COLUMBUS



MAURY JONES, CLU
CINCINNATI



ED GIACO
CLEVELAND



MIKE SEKERAK
CLEVELAND



BOB ROEHL
TOLEDO



CLIFF MOSHER
AKRON-CLEVELAND



Tolinase®
tolazamide, Upjohn

Please contact your Upjohn representative for additional product information.

Upjohn

J-5695-6

©1977 THE UPJOHN COMPANY

Genetic Services in Ohio

A Regional Approach

Antoinette Parisi Eaton, M.D.
John H. Ackerman, M.D., M.P.H.
Alice S. Linyear, M.D., M.P.H.
Eleni Sfakianaki, M.D.

Editor's Note.—*With the need for the practicing physician to know of the availability of genetic counseling and therapeutic services for his patients in today's society, the collaboration of the private and public sectors in genetic services and regional centers is most rewarding.*—**R.L.M.**

Recognizing the importance of genetic studies both to the practicing physician and as a beneficial, preventive, public health program, the Ohio Department of Health is implementing a plan for coordinated delivery of genetic services throughout the state. This article describes the structure, objectives, and benefits of these new services now available in Ohio.

DURING THE PAST TWO decades, significant advances have been made in the field of genetics. This growth in knowledge has had a tremendous clinical impact on the practice of medicine.[1] The relative importance of genetics to the practicing physician is underscored by the fact that over 20 million people — at least one in ten individuals — has, or will later develop, some inherited disorder.[2] In addition, over 2,000 genetic diseases have been identified; they account for 25% to 30% of the admissions to major children's hospitals in the United States and Canada.[2] The need for a health care delivery system designed to provide the necessary genetic services for this segment of the population was emphasized by physicians in the state who were faced with the demands for such services. As a result, a plan was formulated for a statewide network of genetic services in Ohio using a regional approach.

Dr. Eaton, Columbus, Chief, Division of Maternal and Child Health, Ohio Department of Health; and Clinical Professor of Pediatrics, The Ohio State University College of Medicine.
Dr. Ackerman, Columbus, Director, Ohio Department of Health; and Clinical Professor of Preventive Medicine, The Ohio State University College of Medicine.
Dr. Linyear, Columbus, Chief, Bureau of Maternal and Child Health, Ohio Department of Health.
Dr. Sfakianaki, Head, Perinatal Unit, Ohio Department of Health; and Clinical Instructor of Pediatrics, The Ohio State University College of Medicine.
Submitted March 20, 1978.

Additional support of the need for genetic services at the state level was emphasized by the recommendations of the Mental Health and Mental Retardation Committee of the Ohio Comprehensive Health Planning Advisory Council, which stated that "children in need of services in mental health and mental retardation in the state of Ohio should be given high priority."[3] Since they could help prevent severe mental retardation in some instances, it was suggested that genetic services be given careful and immediate consideration.

Importance of Genetic Services

The importance of this recommendation is validated by the fact that of the approximately 155,000 live births in Ohio in 1976, there were 1,734, or 11.2 per 1,000 live births with malformations or anomalies indicated on birth certificates. This figure probably is less than one-half of those that will actually be detected in the same population in a lifetime. The Table provides an estimate of certain disorders in Ohio that are preventable or treatable from the more common — Down's syndrome — to the less common — maple syrup urine disease.

A special study made by the Department of Mental Health and Mental Retardation during the development of this plan revealed that more than 2,800 patients in Ohio's institutions for the mentally retarded were there because of a disorder that is known to be genetic or due to an unknown cause that may have a genetic basis. This points out the need for more services for this segment of the population.[4]

At the federal level, recognition of the importance of genetic programs was indicated by the passage of Public Law 94-278, The National Genetic Disease Act.[5,6] The Forward Plan for Health for Fiscal Year 1977 Through 1981, developed by the Department of Health, Education and Welfare (HEW), reinforces the impact of genetic disorders on the health of the nation.[7] In this document, reference to this health problem is appropriately categorized under prevention. It emphasizes that 4% of the live births in the United States annually have medical problems resulting partially or wholly from a genetic condition categorized as chromosomal, mendelian, or multifactorial. The development of a model state plan for

genetic screening backed by state legislation was recommended, emphasizing that the legal and civil rights of the individual must not be infringed upon. The importance of standards on screening methods, quality review, prenatal diagnostic services, research, and health education also are mentioned in this publication.

Developing the Ohio Genetics Plan

Prior to the development of the Ohio Genetics Plan, involvement of the Ohio Department of Health in the provision of genetic services was on a rather limited basis. In 1965, legislation was passed requiring that all newborn infants be tested for phenylketonuria (PKU). A centralized laboratory service was established at this time within the State Health Department for performance of the Guthrie inhibition assay test on all newborns. More recently, the same specimen has been used to screen for galactosemia and homocystinuria. The state laboratory also can perform tests for sickle cell anemia and hemophilia on request. Special legislation and a state appropriation for the latter two disorders had been acquired. The Division of Maternal and Child Health has played an active role in sponsorship of genetic workshops, follow-up on positive tests from the state laboratory's genetic screening program, and provision of special dietary formula such as Lofenalac.®

Basically, prevention and public health represent the thrust of the "Ohio Plan for Genetic Services." It was the result of considerable effort on the part of Ohio physicians interested in genetics as well as other health professionals over a three-year period.

The regional genetic health care delivery system was developed to represent one component of a comprehensive Maternal and Child Health/Crippled Children's Service program in the State Health Department. It was designed to consolidate "piecemeal" effort and to expand services to persons at risk in all of Ohio and the contiguous boundaries of other states.

The regional approach in planning for rendering this service has been amply justified.[8,9] Reflecting the cooperative efforts of the State Departments of Health, Mental Health and Mental Retardation, Education, and Public Welfare, plus the medical school faculties in the state, The National Foundation — March of Dimes, and the practicing physicians, this genetic plan represented a concerted effort to provide quality comprehensive services to families in need of such services.

Prevention of mental retardation and other developmental disabilities is the principal initial benefit of this specific plan; but the potential for preventing other genetic disorders with serious consequences, such as hematologic disorders, is felt to be clearly a long-term benefit. The secondary gain from this plan, of course, is anticipated in the reduced expenditure of the tax dollar for costly health care programs for rehabilitation of this population with significant handicaps.

The Ohio Department of Health assumed leadership for planning this regional program since it is the public health agency charged with protection of the health of all

Selected Genetic/Metabolic Disorders and Estimated Frequency in Ohio Based on 155,000 Births Per Year*

Disorder	Preventable and/or Treatable	Frequency	Estimated No. Born in Ohio Each Year
Mongolism (Down's syndrome)	X	1: 684	227
Cystic fibrosis	X	1: 2,000	78
Sickle cell anemia	X	1: 3,500	44
Hemophilia	X	1: 3,000	52
Phenylketonuria (PKU)	X	1: 15,000	10
Atypical PKU	X	1: 17,000	9
Galactosemia	X	1: 35,000	4
Tay-Sachs disease	X	1:119,000	1
Homocystinuria	X	1:150,000	1
Maple syrup urine disease	X	1:170,000	1
Hypothyroidism	X	1: 5,000	31
			458

*As of November 1977

Ohioans. Preventive health care, including immunization, protection of the environment, and inspection of food and milk, has long been the primary concern of such state health agencies. However, with major advances in medical knowledge and technology, a broader scope of public health programs is emerging which is expanding the legitimate role of public health agencies. Genetics is clearly such an example.

Goal of the Plan

The specific goal of the genetics plan is to reduce the incidence of developmental disability due to genetic disease and to evaluate the impact of a statewide service delivery network. Six medical-school-based regional genetic centers are being established in cooperation with the State Department of Health. The principal objectives include:

1. *Identifying certain selected genetic and/or metabolic disorders in infants through screening programs* by testing all newborn infants in Ohio for PKU, galactosemia, homocystinuria, and other treatable genetic and/or metabolic disorders. Current planning includes the addition of statewide neonatal hypothyroid screening if the current pilot project is successful.[10] Once a genetic-metabolic disorder is detected, immediate notification of abnormal test results is provided to the referring physician. Information regarding the availability of the genetic service network and referral for specialized diagnostic study, treatment, and follow-up to one of the genetic centers is made available as necessary.

2. *Identifying mothers and families at high risk for genetic disorders* and making the necessary services, including amniocentesis, available.

3. *Providing public and professional information and education at the state and regional center level.* Special emphasis is to be placed on continuing education for health professionals at the primary care level and health

education of the consumer. Special attention to junior and senior high school students via appropriate curriculum development is planned in conjunction with the State Department of Education. Training of allied health professionals to recognize genetic disease and to assist in counseling also is being stressed.

4. *Developing a centralized information system for data correlation and evaluation.* These results will determine if the program will be ongoing since it is very clear that cost-benefit effectiveness must be demonstrated to the Ohio State Legislature and the U.S. Congress for ongoing funding.

Figure 1 is a map of Ohio showing the six major sites of genetic service activity currently in Ohio. The most comprehensive centers are established as regional centers connected with hospitals and medical schools in Cleveland, Columbus, and Cincinnati. The Toledo, Akron, and Dayton centers are being developed as associate centers; they will become regional centers as their genetic program is completely established.

The regional centers are to serve a population of two to four million. The medical school settings provide a wide range of clinical and laboratory services with active education and research programs. It should be noted, however, that because of the rarity of some genetic disorders and the complexity of their diagnosis, expert personnel may not be available within the state system. Hence, a communication and referral network with other centers throughout the nation is essential.



FIG. 1. Regional, associate, and satellite genetic services in Ohio.

The regional centers were selected for several reasons: (1) geographic location and their willingness to interrelate functions and services to avoid costly duplications; (2) to work with the state laboratories to confirm diagnoses in infants and adults suspected of having genetic disorders and to ensure treatment at either the center or at an outlying health facility within a region; (3) to relate center functions to practicing physicians and community hospitals within the region; and (4) to accept standard program evaluation requirements while providing the necessary comprehensive services, ie, clinical evaluation including genetic counseling and public and professional education.

Because of the variety and complexity of genetic disease, a broad spectrum of medical, surgical, and other health related specialists was felt necessary to assist in the clinical and genetic definition of the patient's problem. These support services are readily available at the centers, along with laboratory diagnostic facilities for tissue culture, special chemical tests on urine and blood including analyses for amino acids, abnormal hemoglobins, and immunoglobulins, and enzymological examination for special diagnostic studies on blood cells, serum, urine, and cultured fibroblasts.

Administration

Administratively, the program is based in the Bureau of Maternal and Child Health of the Ohio Department of Health (Fig. 2). Assisting in the task of administering the project will be an advisory body including representatives from other state departments (mental health and mental retardation, education, and public welfare).

The genetic services advisory body is being established. Its purpose is to promote the desired cooperation and exchange between the consumer and the health professionals, as well as to assure public accountability and strong service orientation. A 21-member committee has been proposed with consumer representation.

Funding of this program is a composite of several different sources including:

1. Federal appropriations through Title V of the Social Security Act, which is the Maternal and Child Health/Crippled Childrens Services formula grant to the State of Ohio.

2. State funds for the genetics program in the Fiscal Year 1978-1980 biennial budget.

3. Medical schools and hospitals providing staff and facilities in which the centers are located.

4. Private foundations. Since the initiation of this regional plan, a very significant contribution has been obtained from The Cleveland Foundation to assist the Cleveland Regional Genetics Center.

5. Voluntary contributions from organizations such as The National Foundation - March of Dimes.

6. The Ohio Developmental Disabilities Council, a new and important source of funding.

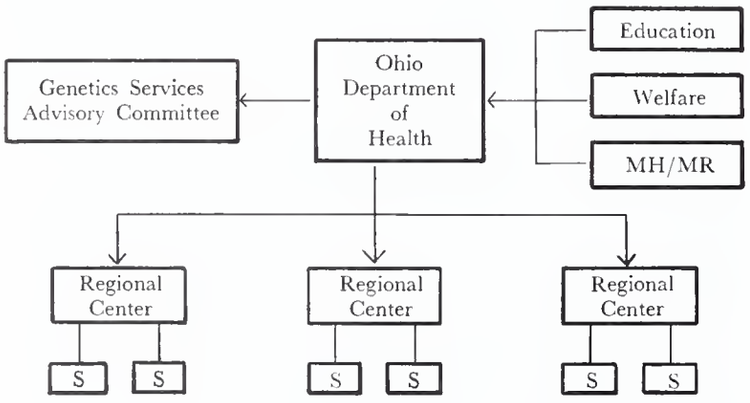
7. The State Department of Mental Health and Mental Retardation supporting laboratory service, principally cytogenetic services at Mt. Vernon State Institute.

8. The Ohio Department of Public Welfare, principally through the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) providing a fee-for-service payment for the Medicaid child.

Summary

The Ohio Department of Health has recognized the importance of genetics both to the practicing physician and as a beneficial, preventive, public health program. The Department is implementing a state plan for coordinated delivery of genetic services in a unique cooperative venture, with the hope that the Ohio model will be successful and, consequently, adopted by other states. The scientific basis for its development is clear. The philosophical concerns can best be quoted as:

"The best hope for reaching the goal of freedom is the prevention of handicapping conditions that rob individuals of their freedom and keep them dependent throughout their lives. Across the nation research is delving into factors that promote healthy human development for those that disrupt development result in damage that is often irreparable. The health and environment of both mother and father even before conception occurs, is of importance because the genetic inheritance will pass on to the child. From conception on to completion of pregnancy, development and differentiation of tissues and organs are major determinants of the eventual intellectual and emotional functioning of the individual. Though research has uncovered many causes of disorders, beginning in the prenatal period, discovering the causes is but one step in the process of correcting the problem. Every baby born with a mental or physical disorder is tragic evidence of the need for further research and application of present knowledge. Preventing handicapping conditions is the best hope of freedom and avoidance of dependency with early and intensive treatment the second best hope."[11] The Ohio Genetics Plan attests to this philosophy.



S = Satellite

FIG. 2. Organization structure of State of Ohio genetic services.

For further information regarding genetic services and patient referral to the regional genetic center, contact any of the following:

Mary Jeanne Metz, Ohio Department of Health, 614/466-8804

Cincinnati Regional Center, 513/559-4691

Cleveland Regional Center, 216/398-6000 ext. 4271 or 216/368-2744

Columbus Regional Center, 614/461-2663

Akron Genetics Center, 216/379-8574

Dayton Genetics Center, 513/226-8408

Toledo Genetics Center, 419/381-3442

Acknowledgment: Ms. Judy Mayhew assisted in the preparation of this manuscript.

Generic and Trade Name of Drug
Low phenylalanine food— Lofenalac (Mead Johnson)

References

1. National Academy of Sciences: *Genetic Screening, Programs, Principles and Research,* Washington DC, 1975.
2. Milunsky A: *Know Your Genes,* Boston, Houghton Mifflin Co, 1977, pp 1-2.
3. Ohio Department of Health: *Ohio Comprehensive Health Planning Advisory Council Report,* April 18, 1973.
4. Arnett EA: *Assessment of Need, Genetic Counseling Services,* in Summary Report #3, Division of Mental Retardation and Developmental Disabilities Operations, Feb 1974.
5. *The National Genetic Disease Act,* Public Law 94-278, 94th Congress, HR 7988, April 22, 1976.
6. Schmidt RM, Curran WJ: A national genetic disease program: some issues of implementation. *N Engl J Med* 295: 819-820, 1976.
7. *Forward Plan for Health, F.Y. 1977-1981.* US Department of Health, Education and Welfare. Public Health Service, 1975.
8. Salisbury AJ: Progress in "regionalization" of perinatal care, in *Clinics of Perinatology,* Philadelphia, W B Saunders Co, 1976, pp 267-270.
9. Merkatz IR, Johnson KG: Regionalization of perinatal care for the United States, in *Clinics of Perinatology,* Philadelphia, W B Saunders Co, 1976, pp 271-275.
10. *Pediatrics Supplement,* Evanston, Ill, Arthur Retlaw and Associates, vol 60, no 3, pt 2, 1977, p 394.
11. *MR 73/The Goal Is Freedom.* The President's Committee on Mental Retardation, Washington, 1973. ☆☆☆

Ohio State Medical Association

Announces 1979 INTRAV Adventure Programs

The Ohio State Medical Association and INTRAV are pleased to offer you an exciting selection of deluxe travel holidays. INTRAV will again be conducting Medical Seminars for Category II CME credit on all trips.



AFRICAN ADVENTURE

Two weeks
Departing February 3, 1979

Leave winter behind . . . escape on a safari to exotic Morocco and the big game country of East Africa. From **Rabat,** explore intriguing Casablanca or the Imperial cities of Marrakech, Meknes and Fez on optional excursions. Then, on to **Nairobi.** Photograph lion, zebra and elephant at a choice of luxurious lodges such as Salt Lick, Tsavo and Masai Mara. Or relax on the golden sands of Mombasa on the Indian Ocean. See the wild game of Africa now . . . before it is too late.



EGYPT/GREEK ISLES

Two weeks
Departing April or May, 1979

Journey back in time into ageless Egypt and the glories of Greece and Turkey. See the great Pyramids and gigantic temples of Giza, Memphis, Sakkara, Luxor and Karnak on excursions from Cairo. Then cruise the transparent waters of the Aegean Sea from Athens through the Greek Isles on Sun Line's intimate **Stella Maris.** Stroll the white-washed streets of Santorini, Hydra and Kos. Relax on rose-covered Rhodes and visit ancient Ephesus in Turkey. Enjoy being pampered for two weeks — you won't want to come home.



RUSSIAN ADVENTURE

Ten days
Departing Summer 1979

Now is the time to visit the Soviet Union as she puts on her finest in preparation for the 1980 Olympics. Walk through massive Red Square, see the Kremlin and the onion-domed churches of the Czars during a three-day stay in **Moscow.** Next a day in **Novgorod,** where Old Russia comes to life in dazzling riches of the past. Then four days in beautiful **Leningrad** . . . a city of pastel-colored palaces, canals, art, music and luxury. Observe first-hand the mystery that is Russia (at one all-inclusive low price).



EASTERN MEDITERRANEAN AIR/SEA CRUISE

Two week cruise
Departing October 1979

A luxury cruise aboard Paquet Line's elegant **Mermoz** to the Holy Land, Greek Isles, Egypt and Istanbul. Enjoy superb international cuisine, entertainment and impeccable service while cruising to Athens, Kusadasi/Ephesus, Istanbul, Mykonos, Alexandria/Cairo, Haifa/Jerusalem and Rhodes. Ride a camel to the Pyramids and Sphinx. Walk the Via Dolorosa in Jerusalem and bargain in Istanbul's colorful Covered Bazaar. Join in the fun-loving spirit of the Greek Isles. Travel in style . . . into the pages of ancient history.

Ohio State Medical Association
600 South High Street
Columbus, Ohio 43215
Attn: Miss Catherine Keeling

Please send me more information on the following 1979 INTRAV/OSMA Adventures:

- ☐ **African Adventure**
- ☐ **Egypt/Greek Isles Adventure**
- ☐ **Russian Adventure**
- ☐ **Eastern Mediterranean Air/Sea Cruise**

Name _____

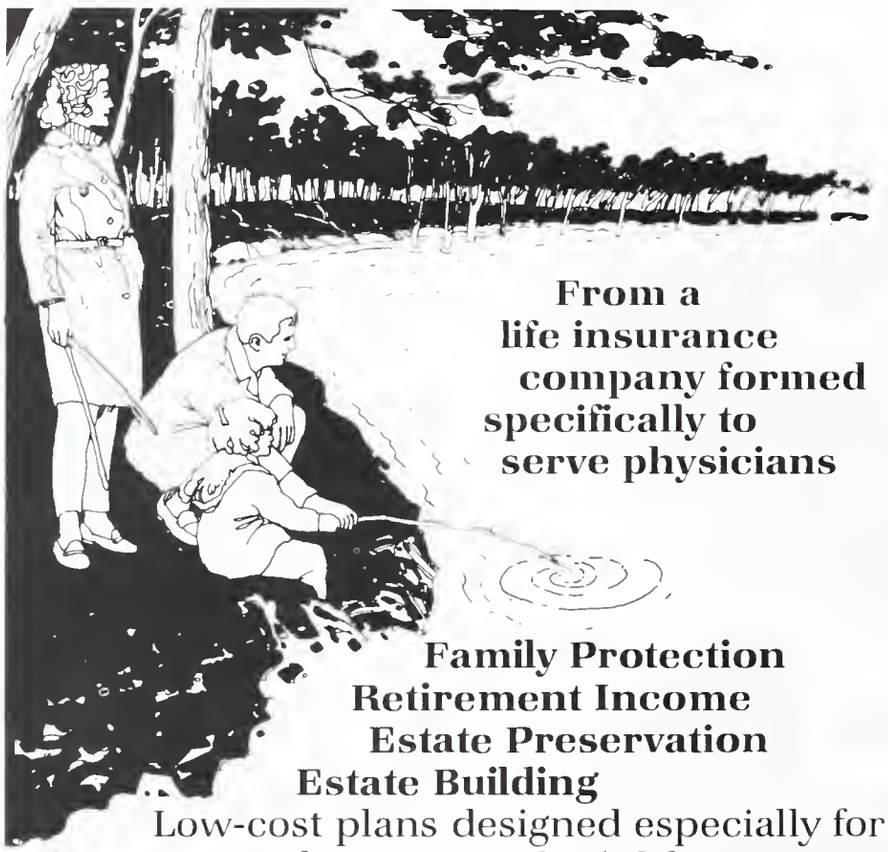
Street Address _____

City _____ State _____ Zip _____

P.S. Some brochures may not yet be available. We will send you all information as soon as possible.

picolife

Life Insurance, With A Difference



From a life insurance company formed specifically to serve physicians

Family Protection
Retirement Income
Estate Preservation
Estate Building

Low-cost plans designed especially for physicians and surgeons...that's life insurance, with a difference.

A Pico Life sales representative will give you a confidential, no-obligation rate quotation on one or several plans that best fit your own particular situation.

Telephone 614-864-0280 or write to the home office to set up a brief appointment.

picolife

Pico Life Insurance Company
6100 Channingway Boulevard
Columbus, Ohio 43227
Telephone (614) 864-0280

A Subsidiary of Physicians Insurance Company of Ohio (PICO)

Valproic Acid: A Brief Review

Robert P. Cruse, D.O.
A. David Rothner, M.D.
Gerald Erenberg, M.D.
Charles Henry, Ph.D.
Kathleen Jugenheimer, B.S.N.

Valproic Acid (VPA) has recently been released for general use in the United States. The Pediatric Seizure Unit at the Cleveland Clinic has been active in the evaluation of this new anticonvulsant. The authors report their clinical experience with it, and present a brief review of the literature. VPA has proved to be nontoxic and effective in the treatment of all types of seizures. It will be a useful addition in the treatment of epilepsy.

THROUGHOUT MANY PARTS OF the world, valproic acid (VPA), n-dipropylacetic acid, is being used to control seizures. This new anticonvulsant is currently undergoing clinical investigation at medical centers in the United States, including the Pediatric Seizure Unit at The Cleveland Clinic Foundation. Valproic acid (Depakene®) has recently been approved by the Federal Drug Administration (FDA) and is now available for general use. This review, based on our clinical experience and the recorded experience of others, is intended to acquaint physicians with this new anticonvulsant.

Valproic (VPA) acid is not a "new" drug. It has been known to chemists since it was first synthesized by Burton[1] in 1881. VPA's anticonvulsant properties were first recognized in 1963 by Meunier.[2] While using VPA as a solvent to suspend new anticonvulsant compounds, he discovered it was the active substance protecting the laboratory animals from seizures induced by Metrazol.® His findings were substantiated by further laboratory and clinical studies.[3] Since 1967, VPA has been used throughout Europe, Japan, and South America for the treatment of seizures.

Dr. Cruse, Hershey, Pennsylvania, Assistant Professor of Pediatrics, Pennsylvania State University College of Medicine. At the time this study was made, he was Special Fellow in Pediatric Neurology, The Cleveland Clinic Foundation.
Dr. Rothner, Cleveland, Chief, Section of Child Neurology, The Cleveland Clinic Foundation.
Dr. Erenberg, Cleveland, Child Neurologist, The Cleveland Clinic Foundation.
Dr. Henry, Cleveland, Chairman, Department of Electroencephalography, The Cleveland Clinic Foundation.
Mrs. Jugenheimer, Cleveland, Pediatric Neurology Nurse Practitioner, The Cleveland Clinic Foundation.
Reprint requests to The Cleveland Clinic Foundation, Desk 87, 9500 Euclid Ave., Cleveland, Ohio 44106 (Dr. Rothner).
Submitted May 26, 1978.

Pharmacology

VPA is an 8-carbon branched carboxylic acid; the structural formula is shown in the Figure. It is rapidly absorbed from the stomach as dipropylacetic acid, and peak blood levels occur within one to four hours. Nearly 90% of the drug is protein bound, principally to albumin. Its distribution is limited mainly to the intravascular compartment and to the rapidly exchangeable extracellular fluid. Cerebrospinal fluid (CSF) levels average one-tenth of the serum level. Concentrations of VPA are found throughout the central nervous system but are highest in the cerebellum. Significant levels also occur in the basal ganglia and brain stem. The half-life of VPA averages eight hours but may range from 4 to 15 hours. Interaction of VPA with other anticonvulsants, particularly phenobarbital, phenytoin, and carbamazepine, may affect their metabolism, cause changes in their half-life, and result in variable anticonvulsant blood levels. Eighty percent of VPA is metabolized by glucuronide metabolism, and only a small portion appears unchanged in the urine. Seventy-five percent of the metabolic products appear in the urine as 2-propyl-5-hydroxypentoic acid and 2-propylglutamic acid. Lesser amounts are excreted in the stool and expired through the lung.

VPA's mechanism of action is unknown. It may alter gamma-aminobutyric acid (GABA) metabolism by competitive inhibition of the enzyme GABA transaminase (GABA-T). The reduced GABA degradation is thought to result in increased levels of GABA in the CNS. GABA is a known neuroinhibitor, and it is this property which is assumed to suppress seizure activity. This hypothesis is based on animal experiments and has not been substantiated in humans. Alternate mechanisms also have been proposed.[4]

Clinical Effectiveness

Over the past ten years, numerous clinical investigators have testified as to the effectiveness of VPA, and the results of nearly 4,000 cases have been reported. The ma-

jority of patients tested were resistant to standard drug therapy and often were receiving a combination of other anticonvulsants. Most of the studies have been "open" and only three double-blind crossover studies have been reported.[5-7] All three studies show VPA to be superior to placebo.

VPA seems to be most effective in the control of generalized seizures, especially in the treatment of simple or complex absence seizures (petit mal). Some consider it to be the drug of choice in infantile myoclonic seizures.[8] Results of a single study indicate that VPA is equal to phenobarbital in preventing febrile seizures.[9] It has been effective in the treatment of focal motor, focal sensory, and complex partial (temporal lobe, psychomotor) seizures. It must be emphasized, however, that VPA has been effective in varying degrees in all types of seizures. In all reports wherein VPA serum levels have been determined, the correlation between serum levels and clinical effectiveness has been inconsistent. Therapeutic VPA blood levels have not been defined clearly and have ranged from 50 μg/ml to 100 μg/ml; toxic levels have not been determined. Blood VPA levels will be of little assistance in managing patients until methodology for determining blood levels, the pharmacology, and therapeutic levels are more clearly established.

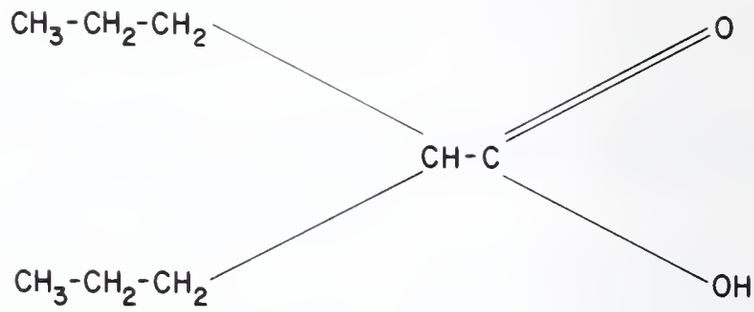
Dosage

The most effective dosage for VPA has not been established. The usual starting dose for adults has been 500 mg per day, increasing by 250 mg every seven days until an average dose of 1,500 mg per day is attained. The maximum dose rarely has exceeded 3,000 mg per day. The common starting dose for children is 15 mg/kg/day, increasing by 5 mg/kg/day each, to an average dose of 25 mg/kg/day, or a maximum dose of 60 mg/kg/day. In the United States, the recommended maximum dose is 30 mg/kg/day. VPA is available in two forms: a syrup (sodium salt of valproic acid) containing 50 mg per cc, and a 250-mg capsule (valproic acid). It usually is administered three times a day, although some have advocated a twice-daily schedule.

Therapeutic Benefit

Full therapeutic benefit of VPA may not be appreciated for as long as six weeks after an effective dosage has been reached. The reason for this is not known. In many patients, dosages of other anticonvulsants may be reduced as seizures are controlled. *In patients taking barbiturates or primidone, sudden rises in barbiturate levels or clinical drug toxicity may necessitate reduction of these drugs.* Interactions also may occur with phenytoin, the succinimides, clonazepam, or other anticonvulsants, and may require alterations in dosage. Reduction in the dosages of other anticonvulsants must be effected slowly to avoid withdrawal seizures.

In addition to the clinical effectiveness of VPA, there has been much enthusiasm concerning the relatively low incidence of significant side-effects. Side-effects do occur,



Structural formula of valproic acid.

but only rarely have they been serious enough to cause discontinuance of the medication.

Adverse Effects

The most common adverse effects of VPA are gastrointestinal. Nausea often accompanied by vomiting or abdominal pain may occur in up to 20% of the patients. In most patients, it is secondary to local gastric irritation, it is not clearly dose-related, and usually takes place shortly after the VPA is ingested. A central form of vomiting is a less common adverse side-effect. It is seen approximately one to three hours after taking a dose of VPA. The nausea and vomiting associated with gastric irritation may be transient or may respond to taking the medication either with meals or with an antacid. If vomiting persists, reduction of the dosage followed by slow increase to the previous dosage usually is effective. Rarely, alterations in appetite may be associated with either mild weight loss or weight gain.

A recent report from England describes severe hepatotoxicity in five patients taking VPA for less than six months;[11] four of the five patients died. The four patients taking additional anticonvulsants died; while the fifth patient who was taking only VPA survived.

Drowsiness commonly occurs when VPA and barbiturates are being taken simultaneously. There is poor correlation with the dosage of either drug and this reaction. Ataxia, tremor, myoclonus, and rarely a "detached feeling" or even a psychotic-like reaction may occur. Reports of increased alertness and improved behavior and mental function have been described, but these beneficial effects may be related to either reduced dosages of other anticonvulsants or improved seizure control.[12]

Increased bruising seldom may occur and is more common in children. The bruising is related to altered platelet function; standard coagulation studies remain normal. Transient thrombocytopenia, and less often leukopenia, can occur but they usually respond to a temporary decrease in dosage.

Mild hair loss has occurred in 0.5% to 5% of the patients, but total alopecia has not been reported.[13] The loss of hair is self-limited and regrowth occurs. Curiously, the new hair may be more curly. A drug rash may be seen on rare occasions.

Other considerations when using VPA include the potentiation of monamine oxidase inhibitors and the excretion of keto acids in the urine. The latter causes a positive urinary reaction for acetone, which may elicit undue concern in patients with diabetes mellitus.

Comments

Our experience with VPA in the Pediatric Seizure Unit of The Cleveland Clinic Foundation is based on the treatment of more than 150 patients with various seizure types and is similar to the experience reported by others. To date, VPA has been effective in varying degrees in the treatment of all seizure types, but of greatest benefit in the control of absence seizures (petit mal). The patients have received between 30 mg/kg/day and 60 mg/kg/day; most have required the higher dosage before achieving significant improvement. Preliminary data in our absence study group show that of 19 patients with intractable absence seizures, all have had more than 33% reduction in seizure frequency, and 13 of these patients are seizure free.

There was neither clear nor consistent correlation between the clinical response and the electroencephalographic (EEG) changes. Nine patients, including eight who were seizure free, showed good correlation between the clinical response and EEG changes. Ten patients, including six with greater than 75% clinical improvement, had variable discrepancies between clinical course and EEG response. Serial anticonvulsant determinations showed trends toward increasing barbiturate, carbamazepine, and ethosuximide levels and decreasing phenytoin levels. VPA levels ranged between 36 μg/ml and 135 μg/ml. In addition to the improved seizure control, there was an additional benefit of reduction of 27 dosages of other anticonvulsants, and the discontinuance of five medications. Despite the reduced dosages, serum levels of the other anticonvulsants remained within the therapeutic range for the most part.

The results in patients with seizure types other than absence have been somewhat less dramatic, but most have experienced improvement. In many patients, an unexpected benefit from VPA has been increased alertness due to either improved seizure control or a reduced dosage of other anticonvulsants.

In our patients, the most common adverse effect has been nausea and vomiting. In most cases, this problem responded favorably to taking VPA with meals, and in no case was discontinuance of the drug necessary. Increased drowsiness and disproportionately elevated barbiturate levels concomitant with the administration of either phenobarbital or primidone with VPA occurred often. Decreasing the dosage of phenobarbital or primidone relieved these symptoms. Two cases of uncomplicated transient thrombocytopenia occurred, and both resolved with reduction in the dosage of VPA. None of the other reported side-effects occurred in our patients.

Summary

The history, pharmacology, and clinical use of VPA based on an overview of the literature and the experience at the Pediatric Seizure Unit of the Cleveland Clinic Foundation are presented. Our experience substantiates the experiences of others and indicates that sodium valproate is effective in varying degrees in seizures of all types and is free of serious side-effects.

Generic and Trade Names of Drugs

Valproic acid— Depakene (Abbott Laboratories)
Pentylenetetrazol— Metrazol (Knoll Pharmaceutical Co.)

References

1. Burton BS: On the propyl derivatives and decomposition of ethyl acetoacetate. *Am Chem J* **3**:385-395, 1882.

2. Meunier G, Carraz G, Meunier Y, et al: Proprietes pharmacodynamiques de l'acide n-dipropylacetique. *Therapie* **18**: 435-438, 1963.

3. Carraz G, Fau R, Chateau R, et al: Communication a propos des premiers essais cliniques sur l'activite antiepileptique de l'acide n-dipropylacetique (sel de Na). *Ann Med Psychol* **2(4)**:577-585, 1964.

4. Pinder RM, Brogden RN, Speight TM, et al: Sodium valproate: a review of its pharmacological properties and therapeutic efficacy in epilepsy. *Drugs* 13:81-123, 1977.

5. Meinardi H: Clinical trials of anti-epileptic drugs. *Psychiatr Neurol Neurochir* **74**:141-151, 1971.

6. Richens A, Ahmad S: Controlled trial of sodium valproate in severe epilepsy. *Br Med J* **4**:255-256, 1975.

7. Suzuki M, Maruyama H, Ishibashi Y, et al: A double-blind comparative trial of sodium dipropylacetate and ethosuximide in epilepsy in children with special emphasis on pure petit mal seizure (in Japanese). *Med Prog* **82**:470-488, 1972.

8. Jeavons PM, Clark JE, Maheshwari MC: Treatment of generalized epilepsies of childhood and adolescence with sodium valproate ("Epilim"). *Dev Med Child Neurol* **19**:9-25, 1977.

9. Cavazzuti GB: Prevention of febrile convulsions with dipropylacetate (Depakene). *Epilepsia* **16**:647-648, 1975.

10. Gram L, Wulff K, Rasmussen, et al: Valproate sodium: a controlled clinical trial including monitoring of drug levels. *Epilepsia* **18**:141-148, 1977.

11. Letter from Richard DeJong, M.D., Abbott Laboratories, to A. David Rothner, Sept. 8, 1977.

12. Sommerbeck KW, Theilgaard A, Rasmussen KE, et al: Valproate sodium: Evaluation of so-called psychotrophic effect. A controlled study. *Epilepsia* **18**:159-167, 1977.

13. Simon D, Penry JK: Sodium di-N-propylacetate (DPA) in the treatment of epilepsy. A review. *Epilepsia* **16**:549-573, 1975.

☆☆☆


"...Sleep that knits up the ravell'd sleave of care..."
– WILLIAM SHAKESPEARE, MACBETH, ACT II, SC. 2

Insomnia
a shade of blue that often accompanies depression

And, in anxiety/depression, Adapin® (doxepin HCl) often helps restore disturbed sleep patterns, such as early morning awakening, with a single daily dose at bedtime[1] Adapin quickly relieves the patient's anxiety, gradually brightens his mood and outlook, with optimal antidepressant response usually evident within two to three weeks.

1. Goldberg HL, Finnerty RJ, Cole JO: Doxepin: Is a single daily dose enough? *Am J Psychiatry* 131:1027-1029, 1974.

Brief Summary of Prescribing Information
ADAPIN® (doxepin HCl) Capsules

Indications—Relief of symptoms of anxiety and depression.

Contraindications—Glaucoma, tendency toward urinary retention, or hypersensitivity to doxepin.

Warnings—Adapin has not been evaluated for safety in pregnancy. No evidence of harm to the animal fetus has been shown in reproductive studies. There are no data concerning secretion in human milk, nor on effect in nursing infants.

Usage in children under 12 years of age is not recommended. MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with this drug, as serious side-effects and death have been reported with the concomitant use of certain drugs and MAO inhibitors.

In patients who may use alcohol excessively potentiation may increase the danger inherent in any suicide attempt or overdosage.

Precautions—Drowsiness may occur and patients should be cautioned against driving a motor vehicle or operating hazardous machinery. Since suicide is an inherent risk in depressed patients they should be closely supervised while receiving treatment. Although Adapin has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Adverse Reactions—Dry mouth, blurred vision and constipation have been reported. Drowsiness has also been observed.

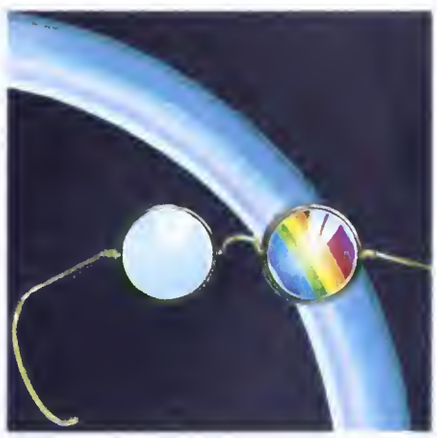
Adverse effects occurring infrequently include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as sweating, tachycardia and hypotension. Weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash and pruritus may also occur.

Dosage and Administration—In mild to moderate anxiety and/or depression: 25 mg t.i.d. Increase or decrease the dosage according to individual response. Daily dosage, up to 150 mg may be taken at bedtime without loss of effectiveness. Usual optimum daily dosage is 75 mg to 150 mg per day not to exceed 300 mg per day.

Antianxiety effect usually precedes the antidepressant effect by two or three weeks.

How Supplied—Each capsule contains doxepin, as the hydrochloride: 10 mg, 25 mg, 50 mg and 100 mg capsules in bottles of 100 and 1000.

For complete prescribing information please see package insert or PDR.



When they see life in shades of blue... help them see life in all its colors.

Adapin®
(doxepin HCl)

single daily dose recommended h.s.



10 mg capsules
25 mg capsules
50 mg capsules
NEW 100 mg capsules

PENNWALT

Pennwalt Prescription Products
Pharmaceutical Division
Pennwalt Corporation
Rochester, New York 14603

ANCEF®

brand of sterile

CEFAZOLIN SODIUM

GETS TO THE SITE



OF SERIOUS RESPIRATORY INFECTIONS

'Ancef' Penetrates Pleural Fluid

"...levels of cefazolin in pleural fluid...generally exceeded the median MICs of all organisms commonly associated with respiratory tract infections, with the exception of a small number of isolates of Klebsiella and H. influenzae.

—Cole, D.R., et al.: Antimicrob. Ag. Chemother. 11(6):1033-1035 (June) 1977.

Tissue penetration is essential to therapeutic efficacy; however, specific tissue levels have not been directly correlated with specific therapeutic results.

Before prescribing, see complete prescribing information in SK&F literature or PDR. The following is a brief summary.

Indications: Ancef® (sterile cefazolin sodium, SK&F) is indicated in the treatment of the following serious infections due to susceptible organisms:

Respiratory tract infections due to Streptococcus pneumoniae (formerly D. pneumoniae), Klebsiella species, Hemophilus influenzae, Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), and group A beta-hemolytic streptococci.

Injectable benzathine penicillin is considered to be the drug of choice in treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. 'Ancef' is effective in the eradication of streptococci from the nasopharynx; however, data establishing the efficacy of 'Ancef' in the subsequent prevention of rheumatic fever are not available at present.

Urinary tract infections due to Escherichia coli, Proteus mirabilis, Klebsiella species, and some strains of enterobacter and enterococci.

Skin structure infections due to Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), group A beta-hemolytic streptococci and other strains of streptococci.

Biliary tract infections due to Escherichia coli, various strains of streptococci, Proteus mirabilis, Klebsiella species and Staphylococcus aureus.

Bone and joint infections due to Staphylococcus aureus.

Genital infections (i.e., prostatitis, epididymitis) due to Escherichia coli, Proteus mirabilis, Klebsiella species, and some strains of enterococci.

Septicemia due to Streptococcus pneumoniae (formerly D. pneumoniae), Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), Proteus mirabilis, Escherichia coli, and Klebsiella species.

Endocarditis due to Staphylococcus aureus (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci.

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to 'Ancef'.

Contraindications: ANCEF (STERILE CEFAZOLIN SODIUM, SK&F) IS CONTRAINDICATED IN PATIENTS WITH KNOWN ALLERGY TO THE CEPHALOSPORIN GROUP OF ANTIBIOTICS.

Warnings: BEFORE CEFAZOLIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY IN PENICILLIN-SENSITIVE PATIENTS.

SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Any patient who has demonstrated some form of allergy, particularly to drugs, should receive antibiotics cautiously. No exception should be made with regard to 'Ancef'.

Usage in Pregnancy: Safety of this product for use during pregnancy has not been established.

Usage in Infants: Safety for use in prematures and infants under 1 month of age has not been established.

Precautions: Prolonged use of 'Ancef' may result in the overgrowth of nonsusceptible organisms. Careful clinical observation of the patient is essential.

When 'Ancef' is administered to patients with low urinary output because of impaired renal function, lower daily dosage is required (see dosage instructions). A false positive reaction for glucose in the urine of patients on 'Ancef' has occurred with Clinitest® tablets solution.

Adverse Reactions: The following reactions have been reported. Hypersensitivity: Drug fever, skin rash, vulvar pruritus, and eosinophilia have occurred. Blood: Neutropenia, leukopenia, thrombocythemia and positive direct and indirect Coombs tests have occurred. Hepatic and Renal: Transient rise in SGOT, SGPT, BUN and alkaline phosphatase levels has been observed without clinical evidence of renal or hepatic impairment. Gastrointestinal: Nausea, anorexia, vomiting, diarrhea, oral candidiasis (oral thrush) have been reported. Other: Pain at site of injection after intramuscular administration has occurred, some with induration. Phlebitis at site of injection has been noted. Other reactions have included genital and anal pruritus, genital moniliasis, and vaginitis.

How Supplied: Ancef® (sterile cefazolin sodium, SK&F)—supplied in vials equivalent to 250 mg., 500 mg., or 1 gram of cefazolin; in "Piggyback" Vials for intravenous admixture equivalent to 500 mg. or 1 gram of cefazolin; and in Pharmacy Bulk Vials equivalent to 5 grams or 10 grams of cefazolin.

ANCEF® IV IM

brand of sterile

CEFAZOLIN SODIUM

(LYOPHILIZED)

Injection: 250 mg., 500 mg. and 1 gram vials

Smith Kline &French Laboratories
Philadelphia, Pa.

SK&F
a SmithKline company

Conservative or Resurfacing Total Hip Replacement

William G. Mishler, M.D.
Thomas H. Mallory, M.D.

Resurfacing total hip replacement, a method recently introduced, serves as an alternative treatment to conventional hip replacement. The procedure allows maintenance of bone stock, but also offers the advantage of resurfacing the articular surfaces of the hip joint with artificial implants. Fifteen patients undergoing 18 resurfacing procedures were reviewed with approximately one-year follow-up and indicated a consistent restoration of hip function characterized primarily by pain relief. Two complications were incurred, one relating to loosening of the component and the other to subsequent fracture of the femoral neck. Both of these complications were attributed to surgical technique related to inexperience with the procedure. In view of the consistent favorable results obtained, it appears that resurfacing total hip replacement can be considered as an alternative treatment in the management of end-stage arthritis affecting younger individuals in which preservation of bone stock is essential.

ALTHOUGH THE FAILURE RATE with conventional total hip replacement is not particularly high, problems may arise with the femoral intermedullary stem fixation.[1,2] Problems of this nature have centered primarily around loosening, cement fracture, and stem failure. Resurfacing total hip replacement, a method recently introduced, may serve as an alternative device.[3] This procedure allows for a maintenance of bone stock, and offers the advantages of resurfacing the articular bearing surfaces of the hip joint with plastic and metal devices which are held to the skeleton with methyl methacrylate (Fig. 1). This report serves as a preliminary introduction to the resurfacing total hip replacement method and our early experience with it.

Dr. Mishler, Columbus, Senior Resident in Orthopedics, Mount Carmel Medical Center.
Dr. Mallory, Columbus, Chief of Orthopedics, St. Ann's Hospital; Active Member, Department of Orthopedics, Mount Carmel Medical Center; Courtesy Staffs, Children's and Riverside Hospitals; and Clinical Instructor, Department of Orthopedics, The Ohio State University College of Medicine.
Submitted June 12, 1978.

Materials and Methods

Fifteen of our patients underwent a total of 18 resurfacing procedures. Operative reports, preoperative and postoperative x-rays and evaluations for each were reviewed with follow-ups approximately one year later. The lateral trochanteric approach to the hip was utilized, and the acetabulum and femoral head were concentrically reamed to accept the largest prosthetic replacement possible. After trial fitting, the component was cemented to the femoral head and acetabulum in an anatomical position. The trochanter was rewired to the lateral shaft of the femur, and routine closure was accomplished. Postoperative management of the patients was consistent with that of conventional total hip replacement, which allows weight bearing as tolerated and a projected convalescent period of eight to ten weeks.



FIG. 1. Resurfacing total hip replacement. Note plastic socket, metal cup with methyl methacrylate fixation.

Clinical Results

The patient sample consisted of nine women and six men, average age at the time of resurfacing being 52 years old. There were ten cases of primary degenerative joint disease, two cases of rheumatoid arthritis. The remaining cases consisted of the arthritis sequellae resulting from Legg-Calvé-Perthes disease, achondroplastic dwarfism, and dysplastic hip disease. Of the 18 resurfacing procedures performed, six were on right hips, six were on left hips, and three patients had bilateral disease. Average weight for the male patients was 95.4 kg (212 lb); average weight for the female patients was 63.6 kg (140 lb). Using the Charnley modification of the Merle d'Aubigne-Postel hip classification system as a means of evaluating hip disability, preoperative and postoperative scores were obtained for this group of patients.[4] With the numerical value of six equaling a perfect score, preoperative scores were: three for the category of pain; three for walking capacity: and three for range of motion. Postoperatively, patients' scores averaged: five for pain, five for walking capacity; and five for range of motion, thus, placing them in the normal or near-normal range for hip capacity and pain relief. Two complications were encountered: a subsequent loosening of the acetabular component which required revision surgery, and a subcapital fracture beneath the cup which necessitated conversion to conventional total hip replacement (Fig. 2).

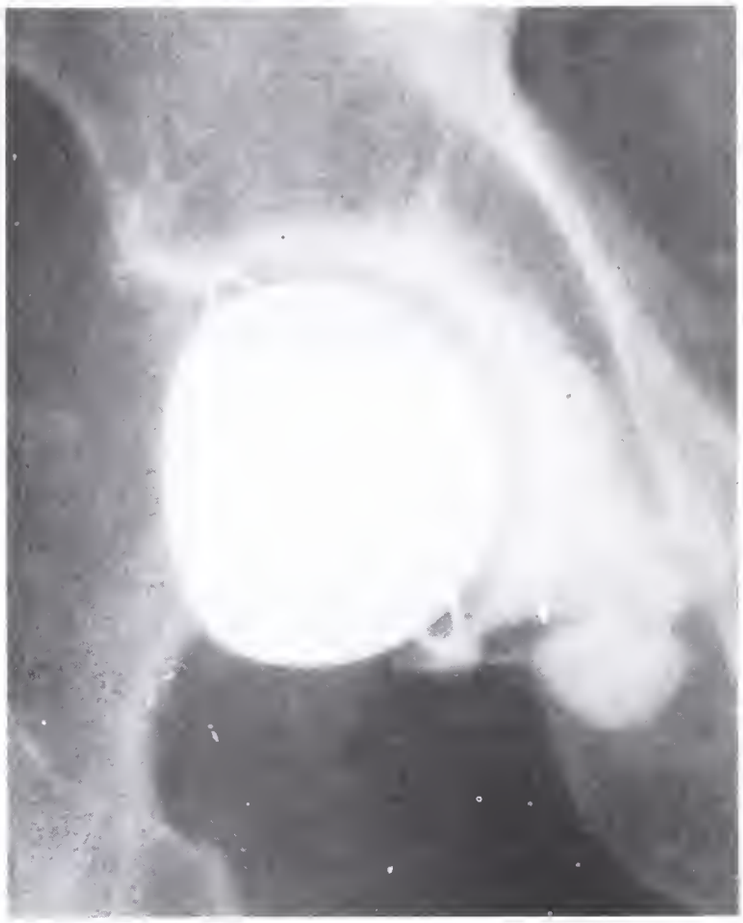


FIG. 2. Subcapital fracture following resurfacing total hip replacement.

Discussion

Early results with resurfacing total hip replacement demonstrate consistent restoration of hip function characterized by relief from pain. The results of our preliminary review of 15 patients undergoing 18 resurfacing total hip replacement procedures reveal a similar phoneomenon. In view of the fact that bone stock is maintained, the procedure is especially applicable to the younger patient with serious hip disease. Hip conditions such as slipped femoral capital epiphysis, Legg-Calvé-Perthes disease, posttraumatic arthritis, and acetabular dysplasia may be amenable to resurfacing total hip replacement. On the other hand, due to the dependency on healthy bone stock, relative contraindications to the procedure exist in the conditions of avascular necrosis, osteoporosis, and rheumatoid arthritis of the hip. It also should be noted that a maintenance of bone stock does not provide the opportunity for correction of discrepancies in leg length.

Resurfacing total hip replacement, then, is a conservative approach in the management of serious end-stage hip disease, particularly in the younger patient. It may well serve as an interim procedure which preserves bone stock and maintains hip function until such time as conventional total hip replacement is indicated. Complications of concern, however, are loosening of the replacement devices, subsequent infection, stress fractures in and about the femoral neck, and trochanter nonunion. In our opinion, the complications encountered in our series will be eliminated eventually as a result of further surgical experience and improved technology. Similarly, information and definite answers to other areas of concern in resurfacing total hip replacement will evolve with the passage of time.

Summary

The results of a preliminary review of 15 patients who underwent a total of 18 resurfacing total hip replacement procedures were evaluated. Preoperative and postoperative evaluation indicated that this procedure appears to give consistent results in terms of pain relief and restoration of hip function. Indications and contraindications for resurfacing total hip replacement are discussed. This procedure may be considered as an alternative to conventional total hip replacement, especially in the younger patient who is experiencing serious end-stage hip disease.

References

1. Collis DK: Femoral stem failure in total hip replacement. *J Bone Joint Surg* **59A**:1033-1041, 1977.
2. Galante JO, Rostoker W, Doyle JM: Failed femoral stems in total hip prosthesese: a report of six cases. *J Bone Joint Surg* **57A**:230-236, 1975.
3. Amstutz HC, Clarke IC, Christie J, et al: Total hip articular replacement by internal eccentric shells: the "Tharies" approach to total surface replacement arthroplasty. *Clin Orthop* **128**:261-284, 1977.
4. Lazansky MG: A method for grading hips. *J Bone Joint Surg* **49B**:644-651, 1967.

☆☆☆

The Ohio State University
Center for Continuing Medical Education

announces

RECENT ADVANCES IN CLINICAL THERAPEUTICS-1978

Saturday and Sunday, December 2-3, 1978
Fawcett Center for Tomorrow
2400 Olentangy River Road
Columbus, Ohio

SPONSORED BY: The Ohio State University College of Medicine Center for Continuing Medical Education, and Departments of Pharmacology, Family Practice, and Medicine

OBJECTIVES: Keeping abreast of important advances in the drug treatment of disease is an important and formidable task for all practitioners of medicine. The major aim of this symposium is to present important facts about selected new drugs and to suggest how these drugs can be used rationally in clinical practice. Crisp, short, formal presentations and opportunities to meet with faculty in small, informal sessions will be available.

VISITING FACULTY:

★ **R. Robert Fekety, M.D.,** Professor of Internal Medicine; Head, Division of Infectious Disease, University of Michigan, Ann Arbor
★ **Charles Hillenbrand, M.D.,** Clinical Instructor, Department of Psychiatry, Loyola University, Chicago
★ **James R. Klinenberg, M.D.,** Director, Department of Medicine, Professor of Medicine, Cedars-Sinai Medical Center, U.C.L.A., Los Angeles
★ **Carlos Lamar, M.D., Ph.D.,** Chief of Medicine, Veterans Administration Hospital; Professor of Medicine, University of South Carolina, Charleston
★ **James K. Luce, M.D.,** Director of Medical Services, Adria Corporation, Columbus, Ohio
★ **John Lukens, M.D.,** Associate Professor, Department of Psychiatry, Michigan State University, Flint
★ **Simeon Margolis, M.D., Ph.D.,** Professor of Medicine; Director, Division of Endocrinology, The Johns Hopkins University, Baltimore, Maryland
★ **Donald L. Meyer, Ph.D.,** Technical Director, Consolidated Biomedical Laboratories, Inc., Columbus, Ohio
★ **Andrew Whelton, M.D.,** Associate Professor of Medicine, Division of Nephrology, The Johns Hopkins University, Baltimore, Maryland
★ **Frederick Wolff, M.D.,** Professor of Medicine, The George Washington University, Washington, D.C.
★ **Avraham Yacobi, Ph.D.,** Associate Professor, Department of Clinical Pharmacology and Drug Metabolism, Arnar Stone Laboratories, Mt. Prospect, Illinois

THE OHIO STATE UNIVERSITY FACULTY:

★ **Joseph R. Bianchine, Ph.D., M.D.,** Professor and Chairman, Department of Pharmacology; Professor, Department of Medicine
★ **Lauren M. Brown, M.D.,** Clinical Associate Professor, Department of Medicine, Division of Infectious Diseases
★ **Moon H. Kim, M.D.,** Associate Professor, Department of Obstetrics and Gynecology
★ **Thomas M. O'Dorisio, M.D.M.,** Associate Professor, Department of Medicine, Division of Endocrinology
★ **George W. Paulson, M.D.,** Professor, Department of Medicine, Division of Neurology
★ **Douglas A. Rund, M.D.,** Assistant Professor and Director, Division of Emergency Medicine
★ **Helmut S. Schmidt, M.D.,** Associate Professor, Department of Psychiatry
★ **John M. Stang, M.D.,** Assistant Professor, Department of Medicine, Division of Cardiology
★ **Fred B. Thomas, M.D.,** Associate Professor, Department of Medicine, Division of Gastroenterology
★ **Paul Weber, M.D.,** Clinical Instructor, Department of Ophthalmology
★ **Ronald L. Whisler, M.D.,** Assistant Professor, Department of Medicine, Division of Rheumatology
★ **Tennyson Williams, M.D.,** Professor and Chairman, Department of Family Medicine
★ **Elizabeth A. Young, M.D.,** Clinical Instructor, Department of Psychiatry

CREDIT: As an organization accredited for continuing medical education, The Ohio State University College of Medicine Center for Continuing Medical Education certifies that this continuing medical education offering meets the criteria for 12 hours in Category I of the Physician's Recognition Award of the American Medical Association and the Ohio State Medical Association provided it is used and completed as designed.
Program is accepted for 12 prescribed hours by the American Academy of Family Physicians.

REGISTRATION: The registration fee of $65 includes lunches, coffee, and all educational materials. Send registration fee on your letterhead, to:

Center for Continuing Medical Education, A352 Starling Loving Hall, 320 West Tenth Avenue, Columbus, Ohio 43210, phone: 614/422-4985.

The Relationship Between Unemployment and Health

John H. Ackerman, M.D., M.P.H.
Mary F. Vaeth, M.D., M.S.

The economic consequences of unemployment hove been studied extensively ond ore well documented, but considerobly less ottention has been given to the domoging effects of unemployment upon heolth. This brief review of the literoture deoling with the relotionship between unemployment ond heolth describes some of the research thot hos been conducted ond reveols the oreos in which further studies ore needed. In view of current economic conditions, the need to increose our efforts in this oreo is becoming increosingly important.

THE RELATIONSHIP BETWEEN unemployment and health is an important issue, particularly in the light of current economic conditions. However, the determination and documentation of the specific effects of unemployment upon health present complex problems for those who attempt to study them. Some complicating problems of the issue are: (1) *Income and medical benefits available to the unemployed.* In many cases, employees do not lose their health insurance benefits immediately when they are laid off. Coverage may continue for up to 13 months for some, and others may be covered under their spouse's policy if the spouse is employed.[1] (2) *Length of unemployment period.* (3) *Income and educational level prior to unemployment.* The utilization of health services, particularly preventive services, and the baseline level of health status are influenced by socioeconomis status.[2] (4) *Length of time necessary for certain physical ailments to develop and manifest themselves.*

The adverse effects of unemployment on health are based on three factors: (1) *Poor nutrition due to an altered diet as a result of decreased food budget.* Nutritional status is especially significant in acute and infectious diseases and in infant development.[2] (2) *Increased sociopsychologic stress which leads to biologic changes, especially fluctuations in hormone levels.* An abnormal pattern of hormonal secretion, along with dietary, hereditary, and other factors, is postulated to be an important factor in the development of many diseases. These include hypertension, eclampsia, diseases of the heart and blood vessels, kidney diseases, rheumatoid arthritis, inflammatory diseases of the skin and eye, infections, diseases with an allergic or hypersensitivity component, nervous and mental disease, sexual derangement, diseases of the digestive system, metabolic diseases, and cancer.[3] (3) *Lack of necessary medical care due to decreased use of health services.* This has been cited as an important factor in maternal and child illnesses, accidents, and cancer.[2]

Research Methods

Research into this issue is notably sparse. A review of the literature reveals four principal methods used to describe and analyze the problem. Since most of the studies made are of a retrospective nature, it is difficult to prove specific causal relationships.

One method is the use of individual case studies. Many health and welfare professionals involved with these cases have observed an increase in the number of cases of child abuse, suicide, admissions to mental hospitals when levels of unemployment are increased. They feel that a significant number of such cases are directly attributable to the loss of employment and sustained unemployment.[4,5]

Another type of research is the use of surveys consisting of questionnaires, interviews, and physical examinations among certain populations of unemployed workers. This type of study was carried out in Canada in the early 1930s under the auspices of McGill University.[6] In the study, they attempted to determine the medical and physical implications of unemployment. The techniques included: complete physical examinations for 1,000 unemployed adults (compared with 1,000 employed men) and 270 unemployed youths, both classified according to occupational or economic status; review of health factors among 600 unemployed families; and detailed examination of nutrition among a specially selected group of families on welfare. Adults examined in this study were

Dr. Ackerman, Columbus, Director, Ohio Department of Health.
Dr. Vaeth, Columbus, Assistant Chief, Division of Chronic Diseases, Ohio Department of Health.
Submitted January 25, 1978.

divided into three classes on the basis of occupation and skill: white-collar, skilled and semiskilled (industrial), and low-skilled and laborers. Analysis of the nutritional status of the workers revealed a greater number of them suffering from underweight and malnutrition in the unemployed industrial class than in the employed industrial class. Other findings included an increase in dental, oral, and nasal abnormalities; increased rate of deafness and other auditory defects; and an increase in cardiovascular defects among the unemployed versus the employed workers. From the standpoint of emotions, anxiety states and feelings of inadequacy were more frequent among the unemployed, particularly among the higher-grade occupational group.

In the study on nutrition, 25 families who had lived at the welfare level of income for a period of five years were interviewed and examined. Slightly less than 50% of them were poorly or insufficiently nourished, and 12½% actually showed marked evidence of malnutrition. When the family was separated into age groups, only about 30% of the adults and 25% of the adolescents (aged 16 years and over) showed poor or fair nutrition, while more than 50% of the juveniles and almost 100% of the children up to 5 years old were poorly or only fairly nourished.[6]

A study made in the United States by the Institute of Human Relations, during the years 1933 to 1939 on groups of unemployed families in New Haven, Conn., found that almost all of the families had had to forego desired medical attention and had decreased and altered their pattern of food consumption due to the lack of income caused by unemployment.[7]

Socioeconomic Status and Health

These studies actually are documentations of the effect of a low economic status on health which can be one of the results of unemployment. A substantial amount of research has been done concerning the relationship between socioeconomic status and health in the past 40 years. This research has demonstrated higher rates of morbidity and mortality attributable to physical disorders, a shorter life expectancy, and an increased prevalence of mental disorders, including child abuse,[8] among lower socioeconomic groups. The rate of use of health care facilities for both physical and mental disorders is lower among these same groups, controlling for age and levels of severity of illness.[2] This excess of physical disorders among lower socioeconomic groups and nonwhites is most evident in the chronic conditions, especially hypertension and cancer of the lung, cervix, stomach, and esophagus.[2] The advent of social welfare legislation provided for some equalization in income distribution and availability of social and medical services. This has improved the situation, but substantial differences still exist among socioeconomic groups.

The most common method used for the study of the relationship between health and unemployment has been the examination of statistical correlations between different indices of health and unemployment rates. This technic is used to test specific theoretic hypotheses, but it cannot be used to establish causation. One of the hypotheses that has been tested by many researchers and has been supported statistically is the positive relationship between economic variations and suicide. After examining the suicide rates in America between the years of 1902 and 1925, Hurlburt noted that they had the greatest increase in years of economic stress and the greatest decrease in a period of prosperity.[9] Dublin found that periods of decreasing business activity and rising unemployment usually were associated with increases in suicide rates.[10]

M. Harvey Brenner, Ph.D., of Johns Hopkins University, is one of the foremost researchers in this field. In his studies, he has noted an inverse correlation between economic change and the mortality rate for heart disease;[11] a positive relationship between psychiatric hospitalization and unemployment;[12] and a short-term inverse relationship between alcohol consumption and per capita personal income which becomes a positive relationship over a long term.[13]

In response to a request by the Joint Economic Committee of the United States Congress, Dr. Brenner submitted a study in October 1976.[2] His study was designed to facilitate national economic policy decisions by translating the results of research on the adverse effects of unemployment and negative reversals into a more usable form for the policymakers. Statistical analyses of the relationships between certain economic and pathologic indices during the years 1940 to 1973 were performed. Economic indices were: rate of unemployment, relative lack of growth or actual decline in per capita income, and rate of inflation. Pathologic indices were: the general mortality rate; the cardiovascular disease and cirrhosis of the liver mortality rates; rate of suicides, homicides, and first admissions to mental hospitals; and the rate of imprisonment. The study demonstrated that all of the pathological stress indices were directly affected by changes in the three economic variables, with changes in the unemployment rate having the most profound effect. Based on this data, calculations were made of the increase in the number of cases of the pathological conditions which resulted from a given increase in the unemployment rate. It was estimated that a 1.4% increase in the number of unemployed, sustained over the six-year period from 1970 through 1975, resulted in 20,240 deaths from heart and kidney disease, 495 deaths from cirrhosis of the liver, 920 suicides, 648 homicides, 4,227 first admissions to state mental hospitals, and 3,340 admissions to state prisons. The study implies that unemployment and other forms of economic distress cause a substantial amount of adverse physical and emotional effects that could be positively affected by alterations in national economic policy.

Finally, a small amount of research has been done using a prospective method which helps to support the previous conclusions. In 1965, Cobb conducted a study of workers at two companies in the process of closing out their operations and compared them to workers who had permanent jobs.[14] Examinations were made of the workers

during the phase of anticipation of unemployment, shortly after the closing of the plant, and 6, 12, and 24 months later. He found significant changes in norepinephrine excretion and in serum creatinine, serum uric acid, and cholesterol levels associated with the stress of job termination. Norepinephrine levels were shown to be significantly elevated before termination of employment and for as long as 12 months afterward. This documentation of the physiologic changes that occurred in men who underwent the experience of unemployment demonstrates that this is a stressful situation adversely effecting the health of those involved.

Summary

This review of the literature dealing with the relationship between unemployment and health describes the positive correlation researchers have found between unemployment and several different pathologic conditions. It also reveals the need for increased research utilizing a prospective method of study in order to definitely establish casual relationships.

References

1. Appelbaum AL: The recession — its impact on hospitals. *Hospitals* **49**:55-59, 1975.
2. US Congress Joint Economic Committee: Achieving the goals of the Employment Act of 1946 — thirtieth anniversary review. Vol 1 — Employment. Paper No 5. Estimating the social costs of national economic policy: Implications for mental and physican health, and criminal aggression, Oct 26, 1976.
3. Kosa J, Antonovsky A, Zola IK (eds): *Poverty and Health: A Sociological Analysis.* Cambridge, Harvard University Press, 1969.
4. Friedman S: Falling apart. *The Progressive* **40**:38-40, 1976.
5. Shaw D: Unemployment hurts more than just the pocketbook. *Today's Health* **54**:23-25, 1976.
6. Marsh LC, Fleming AG, Blackler CF: *Health and Unemployment: Some Studies of Their Relationships.* Oxford University Press, 1938.
7. Bakke EW: *The Unemployed Worker: A Study of the Task of Making a Living Without a Job.* Shoe String, 1969.
8. Gil DG: Physical abuse of children: Findings and implications of a nationwide survey. *Pediatrics* **44**:857-864, 1969.
9. Hurlburt WC: Prosperity, Depression and the Suicide Rate. *Am J Sociol* **37**:714-719, 1932.
10. Dublin LI: *Suicide: A Sociological and Statistical Study.* New York, Ronald Press, 1963.
11. Brenner MH: Economic changes and heart disease mortality. *Am J Public Health* **61**:606-611, 1971.
12. Brenner MH: *Mental Illness and the Economy.* Cambridge, Harvard University Press, 1973.
13. Brenner MH: Trends in alcohol consumption and associated illnesses. Some effects of economic changes. *Am J Public Health* **65**:1279-1292, 1975.
14. Cobb S: Physiologic changes in men whose jobs were abolished. *J Psychosom Res* **18**:245-258, 1974. ☆☆☆

Harding Hospital

ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

MEMBER BLUE CROSS OF CENTRAL OHIO

ADMISSION AND PRACTICES CONDUCTED WITHOUT REGARD TO RACE, CREED, OR NATIONAL ORIGIN

Offering a Full Range of Psychiatric Services

★ Inpatient Services for 120
★ Individual and Group Psychotherapy
★ Professional Adjunctive Therapy
★ Family Therapy
★ Special Care for the Disturbed Patient
★ Day Treatment for Adults and Adolescents
★ Halfway House
★ Family Care
★ Outpatient Treatment
★ Consultation and Evaluation
★ Special Program for Adolescents, Including School

For further information, call (614) 885-5381

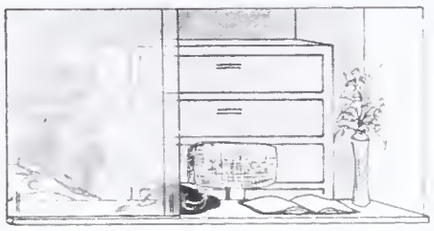
George T. Harding, Jr., M.D.
Medical Director

Donald L Hanson
Administrator

445 East Granville Road
Worthington, Ohio 43085

We create impressions...

First impressions for physicians' waiting rooms. As in the contemporary style shown here, we will design a waiting room that reflects your concern for quality, serenity and most importantly, your patients' total comfort. We will blend style and function in every other room of your office as well. Create an impression . . . call us. We're Medical Interiors, a division of the Wendt-Bristol Company.



AMERICAN SURGICAL TRADE ASSOCIATION A.S.T.A.

medical interiors
a division of THE WENDT-BRISTOL CO.
1107 dublin road p.o. box 144
columbus, ohio 43216

☐ please send a brochure explaining your design concepts.
☐ I'm interested in learning more about MEDICAL INTERIORS.

WB the wendt-bristol company

NAME

ADDRESS

CITY STATE ZIP

OSMJ-10/78

Comparison of National Health Service Systems Who Has the Answers?

Robert S. Daniels, M.D.

Opportunities to study the organization, finance, and manpower requirements of health delivery systems in three foreign countries enabled the author to make observations concerning the impact of an organized delivery system and universal or national payment plan on medical care. The countries observed were England and Scotland, Russia, and Canada. Certain problems and issues are common between the systems observed and that of the United States. These observations may be of value due to the current emphasis on national health insurance in the United States.

CERTAIN PROBLEMS, ISSUES, and opportunities emerge as common to all developed health service systems. The problems of a system reflect those of the socioeconomic-political system of the country, for values and ideals emanating from the social system are incorporated in the health service system. These include: the amount of freedom or control, how an individual may seek help and whether society is responsible for any or all of that service, plurality or multiplicity of services, government control, and reimbursement of professionals and allied individuals delivering the services.[1]

Currently, all the observed systems are being confronted with increasing demands for service. Expectations for availability, continuity, and quality are increasing, as is use of the services. Technical advances are complex and expensive, and costs are increasing more rapidly than the economies as a whole.[2,3] None of the systems has developed effective methods to moderate or to control these factors, and each system has a relatively large proportion of the gross national product involved in health care. In addition, the concept that broader and more complex medical care and more dollars do not lead to better health is beginning to appear.

Finances

All systems are examining questions of cost effectiveness but they are having difficulty doing it rationally. The social and economic cost of illness and disability are hard to evaluate, and it is almost impossible to compare today's costs with those of a few years ago when the patient would have been disabled or have died.

With adoption of the position that health care is a human and social right, countries must decide what is or should be contained in that right— which services are affordable and what is a minimum acceptable level of health care.* With sharply limited expenditures, allotting a larger share of a country's gross national product to health care will be difficult. Most political leaders advocate keeping expenditures at a constant and redistributing the resources to accomplish new objectives. However, if extremely expensive technical interventions may save or sustain life, the question remains how the individuals are chosen to receive such care.

Cost of medical care is associated with personnel, capital improvements, equipment, and treatment. It also is based substantially on the public expectation. Such expectations include type of room accommodations in a hospital or other care facility, quality of food and other personal services, and amount and quality of sociopsychologic support services. Freedom of choice and plurality of opportunity for service also are associated closely with cost.

Decisions about the relative expenditures in various parts of the health care system are important from both functional and economic viewpoints. They are particularly important at such points in the system as the entry site for accessibility and availability of primary care and the relationships between primary care and consultation, outpatient and inpatient care, and the general or community hospital and the referral and/or teaching hospital.

Each country is somewhat aware that a disproportionately small amount of its health care expenditure

Dr. Daniels, Cincinnati, is Dean and Professor of Psychiatry, University of Cincinnati College of Medicine.
Submitted February 22, 1978.

*The public demands increased quantity and quality of service and urges implementation of new lifesaving discoveries in spite of the cost.

is distributed to chronically ill populations. Efforts are being made to change the amount of funds spent to provide more adequate health care and other social services. Since most national situations have limited or no new funds, any shift of money is difficult, oftentimes resisted, and usually from moneys allotted to acute care.

Which services are reimbursed under what circumstances, who delivers the services, and where and how it is delivered are decisions made by government. Eventually, the system must confront the issue of who is qualified to deliver what types of service at what level of reimbursement. These issues frequently evoke territorial questions among specialties and across professions. Service usually follows the reimbursement dollar. Services not reimbursed will tend not to be delivered, or will be delivered by professionals other than those being reimbursed.

Establishing a national or universal reimbursement system strengthens the fiscal capacity and stability of the academic medical center. Typically, such a center has done a large amount of reduced-fee and no-fee work and has cared for a larger-than-average share of the poor and the near poor. In systems in which physicians are partially or fully salaried, the academic physician is usually more highly rewarded than his colleague in private practice. The reverse is customarily true in fee-for-service systems.

Personnel

Each medical system has its own problems with rural and remote-site health care. Isolated and with little service, these areas do not appeal to professionals as places to live. The low-income urban area faces many of the same problems. Incentives such as larger salaries, better fringe benefits, and special privileges are offered to entice physicians to practice in these places. In addition, special transportation and communication systems, personnel, and facilities are inducements. In some countries, indentured service as repayment for the public's investment in the education of a physician supplies physicians to shortage areas. It is difficult to evaluate the impact of these measures on rural and urban health care, but it is clear that all of the systems are moving toward increased government regulatory activity to solve the maldistribution problems.

Each country recognizes that ambulatory medical care is a complex undertaking which requires special training.[4] In England, it has increasing status and, sometimes, higher income. Since patient satisfaction is often closely associated with the availability and accessibility of medical care, questions of ambulatory care systems and manpower are of great importance.

Each nation's interest in ambulatory health care is accompanied by increased length of training in ambulatory care and/or greater concentration on model situations in which education is more likely to be effective. The specialty of family practice in the United States is the most dramatic expression of this development, but Canada and Great Britain also are encouraging longer and more concentrated periods of training in ambulatory care.

The effect of unions on health care systems is increasingly more important. Perhaps the situation is somewhat different in Russia where the extent to which the workers can disagree or effect change is unclear. Industrial action or strikes certainly would be unusual. However, leaders in the Russian system indicate that industrial actions are unnecessary because the workers are satisified.

In the other systems, the labor force at first interests itself in wage and fringe-benefit increases but eventally becomes concerned with working conditions and conditions of patient care. These interests may culminate in desire for increased participation in the management of the health care system. Perhaps the most interesting labor force group are those individuals who historically have been professionals to whom a union was formerly an anathema.

Once this competitive cycle begins, the outcome is not clear. However, there may be a new balance of power within the system. Recently, this change appeared in England, where effective negotiation on the part of the "junior doctors" (the American equivalent of senior house staff and individuals in early medical practice) led to overtime payments. As a result, the junior doctor often has a larger income than the senior consultants. Also, some English technical and nonprofessional workers have contended that the private patients were treated better in health service settings. This has resulted in questions about the future of the private patient, long an important safety valve for the English system.

Health Planning

Each of the systems is striving for more careful and thorough quality control mechanisms for professional practice. These efforts include the quality of care of patients, standardization of the care of disease states with evaluation of situations in which there are exceptions, and unusual use of resources or treatment methodologies. Each system also is exploring opportunities and/or requirements for continuing education, recertification, and/or relicensure. In the more highly controlled and regulated systems, these methods and processes are managed by government; in the less regulated, they are independent and professional, even though government may initiate and require such occurrences.

Malpractice suits or quality control through legal action in the courts remain predominantly American phenomena arising out of our particular set of social and legal checks and balances. Such problems are emerging in Canada and the United Kingdom, but only on a small scale as yet.

All systems are concerned deeply about sensitive and effective mechanisms for developing and improving their health care system. However, data collection has not been refined to accumulate enough information to lead to rational decisions. When data is inadequate and incomplete, decisions are political. Even with good data,

it is very important to recognize in each of the systems how often the policy decisions are political within the larger socioeconomic framework.

Emphasis is on better organized and more efficient systems.[5] This approach must give attention to individuals and their working interrelationships.[6] Too often, political and socioeconomic leaders believe that improving the organizational structure will automatically improve service. Although it may help, the crucial issues are the quality of people, their capacity to relate, to work together, and to produce a sensitive, sensible, realistic, high-quality product.

Some type of government involvement occurs in the more highly organized and regulated systems.[7] In the less regulated, these efforts take the form of broader participation by citizens including the incorporation of new entities which, on occasion, actually own the system and deliver health care. These attempts try to deal with systems that at times seem distant, impersonal, and unresponsive to the needs of the consumer.

In a government-owned service system, local government and professionals must seek advice from local citizens or government concerning the effectiveness and efficiency of the operation of the health system. If the government does not own the health service delivery system, regulatory agencies have the responsibility of planning, gathering data, evaluating, and improving the service system through various review and approval processes. These regulatory activities often are focused on major financial commitments.

None of the systems has a clear opinion as to the role of physicians and nonmedical health system administrators in administering the health care system. Responsibilities vary between systems, within systems, and in particular situations.

Summary

Too often public, political, or professional leaders take the position that some other health care system has the solution to problems which we face. In fact, they almost never do; and even if they did, most of the methods and processes to deal with problems would not be effective because of the differences in the underlying social systems. However, observations of the health care systems of numerous countries provide opportunities to discover to what extent there is a "best way" to improve a health system. They also offer proof to some professional, public, and political leaders that there are no easy solutions to complex social problems.

Should the United States ultimately undertake a national health insurance program, some commonly held expectations are not likely to occur: (1) such a plan will not be developed suddenly; (2) initially, the status quo will be maintained; (3) patients will continue to return to the physicians and the settings in which they previously were served; (4) the initial cost of the plan will be great with gradual tapering off of its escalation; and (5) distribution and function of personnel will not be drastically altered.

References

1. Lisitsin YP (ed): *The System of Public Health Services in the U.S.S.R.*, Moscow, Ministry of Health of the U.S.S.R., 1967.

2. Daniels RS: The British National Health Service: A comparison of the British Health Care Delivery System with that of the United States. *Hospitals* **45**:39-44, 1971.

3. Storey PB: Medical Care in the USSR. Report of the U.S. Delegation on Health Care Services and Planning, May 16-June 3, 1970. Washington, D.C.; U.S. Public Health Service, National Health Institutes of Health, 1972 [DHEW Publication No. (NIH) 72-60].

4. Hardie MC: Islands of change: A review of health service development in Britain. *Hosp Admin* **14**:7-40, 1969.

5. Daniels RS: Health planning in the U.S.S.R.: Are there lessons to be learned? *Am J Public Health* **64**:613-615, 1974.

6. John E. Fogarty International Center for Advanced Study in the Health Sciences. Geographic Health Studies. The British National Health Service: conversations with Sir George E. Godbar, Bethesda, Md. Dept. of Health Education and Welfare, Public Health Service, National Institutes of Health [DHEW Publication No. (NIH) 77-1205].

7. Department of Health & Social Security Green Paper. *The Future Structure of the National Health Service.* London, Her Majesty's Stationery Office, 1970. ☆☆☆

Like a trip to New England . . .

Famous

CRUTCHER

INDIANAPOLIS ANTIQUE SHOW

October 26-29

State Fairgrounds, 1500 E. 38th (U.S. 36)

Investment Quality

Many National Dealers

144 dealers— many from East. Free parking.

Admission $2-$4 days

11 AM-10 PM, Sunday 12 NOON-5 PM

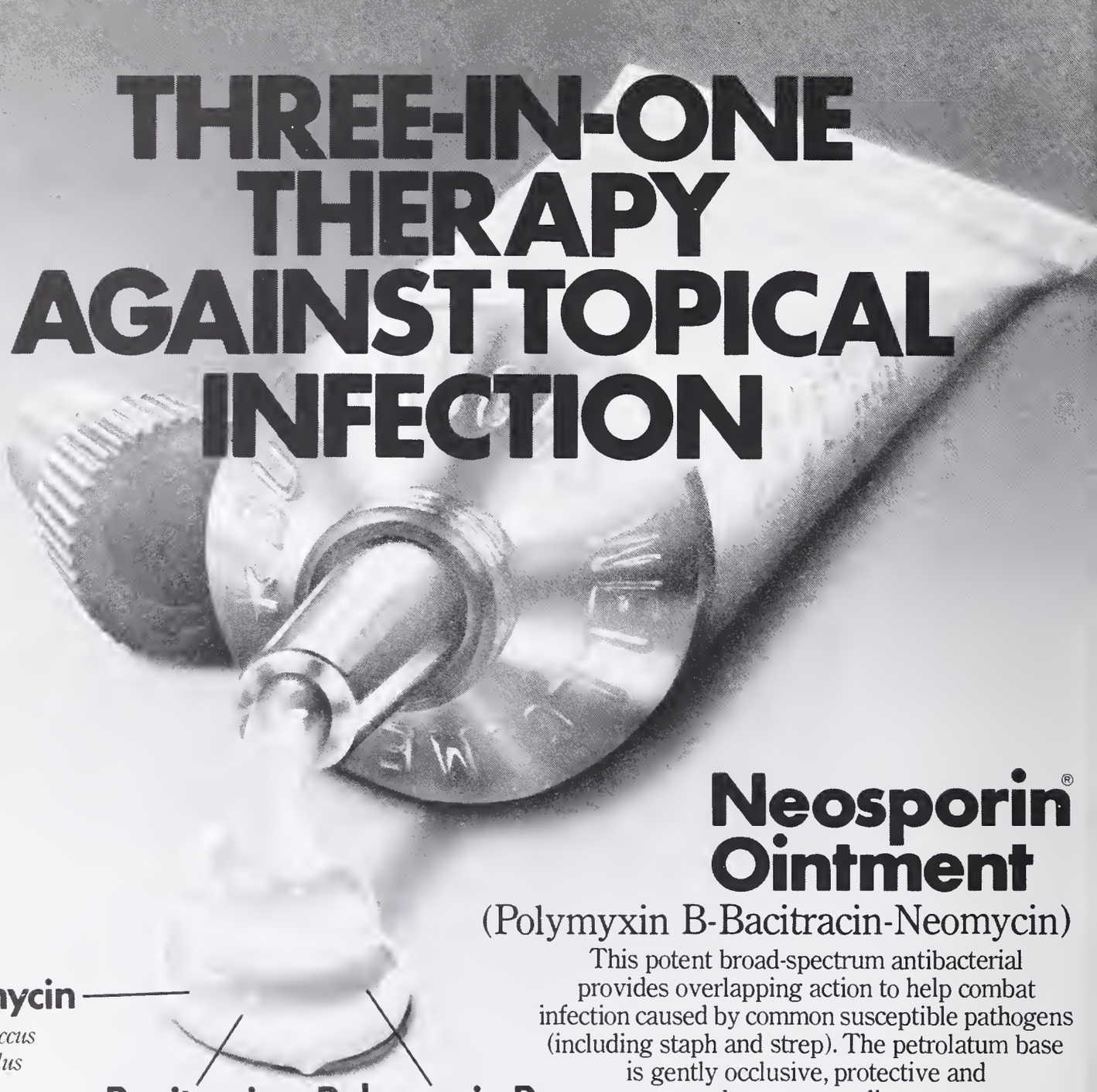
Quality Controlled. Everything Guaranteed.

The only antique show in the U.S.A.

money-back guaranteeing everything.

No other Indiana show compares in any way!

THREE-IN-ONE THERAPY AGAINST TOPICAL INFECTION



Neosporin® Ointment

(Polymyxin B-Bacitracin-Neomycin)

This potent broad-spectrum antibacterial provides overlapping action to help combat infection caused by common susceptible pathogens (including staph and strep). The petrolatum base is gently occlusive, protective and enhances spreading.

Neomycin

Staphylococcus
Haemophilus
Klebsiella
Aerobacter
Escherichia
Proteus
Corynebacterium
Streptococcus
Pneumococcus

Bacitracin

Staphylococcus
Corynebacterium
Streptococcus
Pneumococcus

Polymyxin B

Pseudomonas
Haemophilus
Klebsiella
Aerobacter
Escherichia

In vitro overlapping antibacterial action of Neosporin® Ointment (polymyxin B-bacitracin-neomycin).

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Neosporin® Ointment

(Polymyxin B-Bacitracin-Neomycin)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

Humanistic Medicine
William Osler and Medical Education

Alvin E. Rodin, M.D.

Editor's Note.— *The principle embodied in Dr. Rodin's article is sound, provocative, and worthy of consideration by any physician who is interested in the future of American medicine and American medical education.* R.L.M.

The delivery of effective health care by physicians involves not only knowledge of the basic, social, and clinical sciences of medicine, but also orientation to humanism. Based partly on ethics, humanism is largely attitudinal, being expressed as a concern and caring for patients as worthy and "feeling" human beings. William Osler [1849-1919] still is considered the "ideal" physician because of his combination of scientific knowledge, diagnostic skills, and humanistic interpersonal relationships. Since Osler's death, the massive increase in medical knowledge, together with the ability to cure disease and to delay death, has lead to a decrease in "tender, loving care." Such a trend is responsible, in part at least, for the increasing dissatisfaction of the public with physicians in general. Several modifications in medical education are suggested to reverse this trend.

BEFORE DISCUSSING HUMANISTIC medicine, the term itself must be defined, at least in the context of this presentation. The word "humanistic" obviously is an adjective but, not so obviously, it can be used to refer to two nouns.[1] The first of these nouns is "the humanities" which refers to areas of study such as history, literature, language, philosophy, and art. The humanities are distinguished from the sciences. For example, in medicine, there are the "hard" basic sciences such as anatomy, biochemistry, physiology, microbiology, pathology, and pharmacology; the "soft" social sciences such as psychology, sociology, and anthropology; and the so-called "clinical" applied sciences which correlate and apply the hard and soft sciences for the diagnosis and treatment of disease.

Presented in part at the meeting of the Society for the History of Medicine and Health Sciences of Wright State University, Dayton, Ohio, January 28, 1978.

Dr. Rodin, Dayton, Professor and Chairman, Department of Postgraduate Medicine and Continuing Education, Wright State University School of Medicine; and Director of Medical Education, Greene Memorial Hospital, Xenia.

Submitted February 23, 1978.

The second noun is "humanism," which can be defined as any system of thought or action in which human interests, values, and dignity predominate.[2] It is in this sense that we are using the term "humanistic medicine." Reference is not to the application of the medical sciences to patient care, but the manner in which they are applied. A physician is practicing humanistic medicine if he or she shows a concern for the patient as a human being, not merely as the carrier of disease; if he develops some empathy with the patient; if he is concerned with the comfort of the patient. For example, he will not speak of the patient as a "case," nor will he refer to a specimen of cancer that killed a patient as a "beautiful example." The humanistic physician, therefore, is the opposite of the aloof physician.

If there is a body of knowledge related to humanism, it is the study of ethics. But humanism does not fall completely into the category of knowledge or skills, as do the hard, soft, and clinical sciences of medicine. Instead, it is largely in the realm of attitudes — an acceptance of and commitment to the uniqueness and worthiness of each human being, and a dedication to the improvement of his or her well-being, both emotionally and physically. Some have mistakenly equated the development of humanistic behavior with the study of the humanities. There is not necessarily any correlation of knowledge of such areas as history, literature, philosophy, and art with humanistic attitudes. (The Nazis were enthusiastic art collectors.)

The ideal physician should have appropriate knowledge, skills, and attitudes for effective delivery of health care. With knowledge only, he is a scholar; with skills only, he is a technician; with both, he is a professional who may or may not behave humanistically; with only humanism, he may well be a menace to health. It is the combination of humanism with scientific knowledge and skill that exemplifies the "ideal" physician. Such a physician was William Osler.

William Osler

Sir William Osler is considered by many as the prototype of the modern physician who is both scientifically expert and humanistically oriented.[3] Born in 1849, the year after the development of a test for sugar in the urine,

and dying in 1919, the year before the discovery of insulin, his lifetime encompassed the period of transition from 2,000 years of speculative medicine to the past 100 years of scientific medicine. Osler greatly influenced the practice of medicine and medical education during his career as professor of medicine — McGill University (Canada), University of Pennsylvania and Johns Hopkins University (United States), and Oxford University (England).[4]

During his professional career, he published over 1,000 papers, several collections of his lectures, and a major textbook of medicine.[5] All these contained the latest knowledge and concepts of the time. He was one of the first to recognize the significance of bacteria in endocarditis, and the role of syphilis in aneurysms. But not all of Osler's publications relate to the basic and clinical sciences of medicine. Some are printings of speeches that he gave to many groups including medical societies and medical school classes. It is in these that we see the humanistic physician emerge.

Some of Osler's speeches and essays are in the category of the humanities, eg, the history of medicine, and medicine in literature. More pertinent to this discussion are his essays relating to humanism. The best known is called "Aequanimitas," in which he extolls the Class of 1889 of the University of Pennsylvania to maintain coolness and presence of mind under all circumstances, but at the same time, not "hardening the human heart by which we live."[6]

But a physician's humanism should not be judged by his writings alone. Osler's reputation as the epitome of the kind and considerate physician developed during his lifetime. There are many eye-witness accounts of his "bedside manner" recorded by physicians, medical students, and patients.[7] His humanism was not directed to mankind as an abstract concept, but to the individual patient. His empathy with and compassion for each individual patient is almost legendary now. He exhibited interest, warmth, and humor in his relationships with both patients and students. He spent considerable time playing with both well and sick children.[8] Such humanistic behavior, combined with scientific and clinical expertise, accounts for the adulation with which Osler is regarded 50 years after his death.

Books and papers about William Osler continue to be published at a steady rate even now.[9] Garrison, the medical historian, has summarized why Osler is still considered as an ideal physician, the greatest of our time: "He was one of nature's chosen. Good looks, distinction, blithe, benignant manners, a sunbright personality, radiant with kind feeling and good will toward his fellow men, an Apollonian poise, swiftness and surety of thought and speech, every gift of the gods was his; and to these were added careful training, unsurpassed clinical ability, the widest knowledge of his subject, the deepest interest in everything human, and a serene hold upon his fellows that was as a seal set upon them."[10]

Medical Education

William Osler was as unique in his time as he would be in ours. However, a review of his professional activities highlights some differences in the practice of medicine between the last 50 years and the 50 years before that. There is more dissatisfaction with physicians in general now than before, in spite of their greatly enhanced ability to relieve pain, cure diseases, and delay death.[11] Most complaints by the public are related to the depersonalized relationship of physicians with patients. Until 40 years ago, physicians could do nothing more for patients with pneumonia than provide tender, loving care. And yet, in some ways, people were more satisfied with physician services than at present, when pneumonia is eradicated with a few injections of penicillin. The availability of specific drug therapy appears to have eliminated the need for tender, loving care. Or has it? Recent surveys of patients strongly indicate that desired characteristics in physicians do not relate to the treatment of diseases as such, but to the extent that their doctors talk to them, to the amount of time spent with them, and to the length of time spent waiting for them.[12]

To extrapolate, I propose that the overwhelming increase in scientific medical knowledge during the past 50 years has led to an atrophy of humanistic medicine. A major contribution to this decrease was the survey of medical schools by Abraham Flexner in 1910.[13] This resulted in the first half of the curriculum being devoted almost exclusively to the basic sciences. Rapidly following were the discovery of "miracle" treatments of diabetes by insulin, infections by antibiotics, and tumors by chemotherapy. Such a list is growing constantly, as is patient dissatisfaction with health care delivery.

I am suggesting that this massive increase in the amount of scientific medical knowledge is partially responsible for the marked decrease in humanistic medicine. There are several reasons for this inverse relationship.

1. To obtain medical students who can cope with the large amount of information in the curriculum, college students are selected who have exhibited high achievement in science courses.

2. The enormous amount of data that medical students are required to learn in order to graduate allows them little time for any considerations or appreciations other than those directly related to passing examinations.

3. The necessity for students to achieve satisfactory grades on innumerable tests of scientific knowledge provides continual reinforcement of the primacy of scientific knowledge.

4. The overwhelming emphasis on scientific information orients the student to the disease, to the exclusion of consideration of the human being in whom the disease resides.

5. The massive amount of knowledge about diseases has necessitated specialization limited to certain diseases or areas of the body, with neglect of the patient as a human entity.

This listing is an indictment of both medical education and medical practice, not as a science but as a humanistic endeavor. The consequent dissatisfaction by the public is leading to increased government intervention, to the rise of irrational systems of healing, and to the

resurgence of quackery. Quack healers are successful in attracting patients, in spite of their scientific ignorance, because they have skills which instill confidence, acceptance, and loyalty — all of which relate to interpersonal relationships and not to scientific know-how.

What, then, can be done to develop the "ideal" physician who is oriented to both science and humanism? Few of us have the natural endowments of William Osler. But medical education can be altered so that the patient as a human being becomes the primary focus, rather than the disease with which he is afflicted. Several changes can be made which will provide orientation to the true object of medical care — the human being — while maintaining the scientific content of the curriculum.

1. In choosing from applicants for admission to medical school, place equal emphasis on humanistic attitudes and achievement in college courses. Quantification of the former is more difficult, but it can be achieved by consideration of extracurricular activities, oral interviews, and sophisticated written instruments.

2. Begin the medical school experience with a three-to-six-month, full-time apprenticeship with a carefully selected, humanistic physician. This is a major advantage in that students start with an orientation to the patient as such, rather than with an overriding concern for the structure, function, and diseases of various parts of the body. Another benefit is the initial overview of medical care which affords the student a sense of the relevance and importance of the knowledge he will be expected to acquire.

3. Provide learning experiences for students that will increase their sensitivity to themselves and others as "feeling" individuals, eg, sensitivity groups and role playing as patients.

4. Provide medical students with direct experience as a patient. Each student could be admitted as a patient to a hospital for several days of health investigation, including history, physical examination, x-rays, and laboratory tests. Thus, the student experiences the trials and tribulations of being a patient. There is no better way to develop empathy with patients.

5. Enhance faculty behavior as humanistic role models for students by exposing the faculty to appropriate development activities such as small group discussions, role playing, and evaluation of video tapes of doctor-patient interactions.

These are some changes in medical education that may help to develop more humanistic physicians. We cannot expect all physicians to be as humanistic as William Osler; but at least we can pay more than lip service to the admonition he gave to the students of Albany Medical College in 1899:

"Be careful when you get into practice to cultivate equally well your hearts and your heads. There is a strong feeling abroad among people that we doctors are given over nowadays to science — we care much more for the disease and the scientific aspects of it than for the individual. I would urge upon you to care more particularly for the individual patient than for the special features of the disease. Dealing as we do with poor, suffering humanity, we see the man unmasked or, so to speak, exposed to all the frailities and weaknesses. You have to keep your heart pretty soft and pretty tender not to get too great a contempt for your fellow creatures. The best way to do that is to keep a looking-glass in your own hearts, and the more carefully you scan your own frailties, the more tender you are for the frailties of your fellow creatures."[14]

Summary

Sir William Osler is still considered the prototype of the "ideal" physician because of the humanistic manner in which he applied his abundant medical knowledge and diagnostic skills. The comparative superabundance of such knowledge and skills available to physicians today has led to an increase in considering patients merely as carriers of disease and less relating to them as "feeling" human beings. Such an attitude is responsible, at least in part, for public dissatisfaction with physicians. Some changes in medical education are essential if medical schools are to graduate physicians with a heightened awareness of patients' need for a more humanistic approach by physicians.

References

1. Bates DG: Humanism in undergraduate medical education, in McGovern JP, Burns CR (eds): *Humanism in Medicine,* Springfield, C C Thomas, 1973, pp 109-113.
2. Stein J (ed): *The Random House Dictionary of the English Language,* New York, Random House, 1967, p 691.
3. Knight JA: The relevance of Osler for today's humanity-oriented medical student, in *Humanism in Medicine,* Springfield, C C Thomas, 1973, pp 90-98.
4. Cushing H: *The Life of Sir William Osler.* London, Oxford Clarendon Press, 1925.
5. Abbott ME (ed): *Classified and Annotated Bibliography of Sir William Osler's Publications* (ed 2), Montreal, Medical Museum McGill University, 1939.
6. Osler W: *Aequanimitas, With Other Addresses to Medical Students, Nurses, and Practitioners of Medicine* (ed 3), Philadelphia, Blakiston, 1932, pp 3-11.
7. Martin CF: Osler as clinician and teacher, in *Sir William Osler Memorial Number,* Bull IX, Int Assoc Med Museums, 1926, pp 41-46.
8. McGovern JP, Davison WC: Osler and children. *JAMA* **210**:2241-2244, 1969.
9. Nation EF, Roland CG, McGovern JP: *An Annotated Checklist of Osleriana,* Kent, Ohio, Kent State Univ Press, 1976.
10. Garrison FH: *An Introduction to the History of Medicine,* Philadelphia, W B Saunders, 1929, p 361.
11. Magraw RM: *Ferment in Medicine: A Study of the Essence of Medical Practice and Its New Dilemmas,* Philadelphia, W B Saunders, 1966, pp 20-27.
12. Blackwell RD, Talarzyk WW: *Consumer Attitudes Toward Health Care and Medical Malpractice.* Columbus, Ohio, Grid Inc, 1977, pp 27-42.
13. Flexner A: *Medical Education in the United States and Canada: A Report to the Carnegie Foundation for the Advancement of Teaching.* New York, Carnegie Foundation, Bull 4, 1910.
14. Osler W: Address in *Albany Medical Annals,* 20:307-309, 1899.

☆☆☆

The Ohio State University
Center for Continuing Medical Education

announces

GERIATRIC CARDIOLOGY

Cardiac and Vascular Diseases in the Elderly

November 29, 1978

Hilton Inn, Olentangy River Road

Columbus, Ohio

This seminar will present infarmatian about the impartant, unique features of geriatric cardiovascular diseases that will enable physicians to imprave their capabilities in diagnasis and treatment af elderly patients.

In particular, students af the caurse will learn the differential aspects of the age-associated alteratians in heart structure and cardiavascular hemadynamics which will increase their ability ta recognize these phenamena sa they can clinically improve detectian and application af current diagnastic and therapeutic pracedures.

They will learn haw to mare safely and effectively use medicatians far cardiovascular diseases by understanding impartant aspects af the pharmacokinetics af drugs and basic pathagenesis af vascular diseases in the elderly.

This caurse will teach impartant clinical features af cardiac arrhythmias, valvular disease, and acclusive vascular disease as seen in the elderly. Physicians will imprave their ability ta recagnize these diseases and to apply naninvasive diagnastic techniques.

Very importantly, and unique ta this field, these informative practices will be summarized and placed into the oppropriate context af geriatric care.

FEATURED GUEST SPEAKER

EUGENE STEAD, M.D.

Professor of Medicine, Duke University
Noted Authority on Aging

FEATURED OHIO STATE UNIVERSITY FACULTY

THOMAS G. SKILLMAN, M.D.

Professor of Medicine

For Registration Information

Contact the Center for Continuing Medical Education, A352 Starling Loving Hall, 320 West Tenth Avenue, Columbus, Ohio 43210, phone: 614/422-4985.

Legislative Update

the state scene

(Courtesy the OSMA Department of State Legislation)

Committee Reviews and Revises Coroner's Testing Bill

In one hearing, the Senate Education & Health Committee considered and favorably recommended HB 1118 (Crossland, D-Akron). Proponent testimony was presented by the sponsor and the Summit County coroner, A. H. Kyriakides, M.D. The OSMA testified against the legislation as presented and recommended adoption of a series of amendments to revise both the intent and impact of the legislation. The legislation would have permitted a coroner to conduct "health related testing." The undefined term, health related, was replaced by "testing for suspected toxic substances in emergencies." In addition, the language that permitted the coroner to decide when and if this testing program should be initiated was deleted.

The OSMA Laboratory Medicine Committee had expressed reservations on this expansive statuatory permission for laboratory tests by a coroner. In addition, the bill did not include any quality assurance controls on the services to be provided by a coroner. As amended, the bill requires that prior to initiating and offering these services, the coroner's laboratory must meet all state and federal certificate-of-need, health-planning, and quality-assurance requirements.

SB 163 Controversy Heating Up

SB 163 (Jackson, D-Cleveland), proposing to permit nonmedically trained optometrists to administer "diagnostic pharmaceutical agents," probably will be reconsidered during the November session of the 112th General Assembly. The bill has remained in the House Judiciary Committee since failing to be passed when first brought up for a vote in April. At that time, a majority of the committee members believed SB 163 was not in the best interest of the patient.

Since the April vote, the OSMA, the Ohio Ophthalmological Society, and the Ohio Optometric Association have been meeting together at the request of House Judiciary Committee Chairman Harry Lehman (D-Cleveland) to attempt to resolve the differences between the groups. With little time remaining, the optometrists and the prime sponsor, Assistant Senate Majority Leader Jackson, are pushing very hard for reconsideration even though the differences between the groups have not been resolved.

Regardless of specialty, physician contacts are needed immediately to inform the members of the House and particularly the members of the House Judiciary Commit-

(continued on next page)

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

OHIO OFFICES:

CINCINNATI: Room 700, 3333 Vine Street, (513) 751-0657, L. A. Flaherty

CLEVELAND: Suite 106, 23360 Chagrin Boulevard, Beachwood 44122, (216) 464-9950

A. C. Spoth, Jr., R. A. Zimmermon

COLUMBUS: 1989 West 5th Ave., (614) 486-3939, J. E. Honsel

TOLEDO: 1011 Sandusky St., Suite H, P.O. Box 331, Perrysburg 43551, (419) 874-8080, R. E. Stallter

State Update *(continued)*

tee of the potential problems of nonmedically trained optometrists being allowed to administer dangerous drugs and make diagnoses without adequate training. Physician contacts were the deciding factor when the bill was stopped in April. The Optometric Association has expended a great deal of money and effort toward the passage of Senate Bill 163. They can be expected to exert intense pressure during the next two months for passage.

Bill of Rights Approved for Nursing Home Patients

A comprehensive bill of rights for nursing home patients, Am. Sub. HB 600 (Hartley, D-Springfield), was approved by the Senate (27-4) and returned to the House for concurrence in changes. John Mahoney (D-Springfield), the Senate sponsor, said the bill spells out 29 basic rights of nursing-home patients that cannot be abridged.

Senator Ben Gaeth (R-Defiance) called the bill another example of government dictating to private enterprise and predicted that lawyers would "relish" the bill. He agreed that conditions in some nursing homes are "deplorable," but said homes should be allowed to voluntarily institute the requirements spelled out in the bill. He contends there are already adequate methods of forcing compliance within the intent of the bill.

Although supporting the bill, Senator Marigene Valiquette (D-Toledo) pointed out that the Senate was acting on a House bill to insure the rights of nursing-home patients, while the House has taken no action on a bill giving these same basic rights to hospital patients (SB 202), which she sponsored and which passed the Senate last September 29.

SB 349 Heard in Subcommittee

The subcommittee of the House Finance Committee, which is reviewing the proposed changes to Ohio's Certificate-of-Need (CON) Law, met in September to consider the first of over 150 amendments submitted thus far to Sub. SB 349. This controversial and complex bill seems understood only by Chairman of the Subcommittee, Larry Christman (D-Englewood), and Robert Taft (R-Cincinnati), the Legislative Service Committee (LSC), and the Senate staff that drafted it. It remains the position of the OSMA that this legislation is unnecessary in light of the adoption of certificate-of-need regulations by the Ohio Department of Health, which can be amended by the Department to comply with changes in the federal law without going through lengthy legislative amendments.

Mr. Christman intends to have a "bill" ready for review by the full Committee and ultimate passage by the House during the three-week session after November's election.

IMMKE CIRCLE LEASING INC

Endorsed Leasing Company
Of The Ohio State Medical Association

Order now for early delivery on all 1979 models

We lease all foreign and domestic makes and models
including Mercedes, Jaguar, Porsche, etc.

Many people think of leasing as just automobiles.
We do that too, but, in addition, we want to lease you any professional equipment.

Immke Circle Leasing, Inc.
32 South Fifth Street
Columbus, Ohio 43215

Telephone 614-228-1701 or Toll Free 1-800-282-0256

OHIO STATE MEDICAL ASSOCIATION

AFRICAN ADVENTURE

Is Morocco and Kenya. Wander the narrow streets of the Casbahs in ancient Rabat and mysterious Casablanca. Shop in colorful souks. Visit Djemaa El Fna Square in Marrakech, teeming with storytellers, snake charmers and soothsayers. Roam the vast game parks of Kenya by safari rover. Capture elephant, zebra and lion on film. Relax at luxurious lodges or take a trip into Masai and Kikuyu native villages. Lounge on the sands of Mombasa and let the warm Indian Ocean soothe you. Discover enough native artifacts to start your own museum.



Join our two-week Adventure to the land that fascinated Hemingway — before it disappears forever. We depart Cleveland and Cincinnati on February 3, returning on February 17, 1979. Leave winter behind ... escape to Africa.

$1598
Includes chartered round-trip jet flights, deluxe hotel in each city, full American breakfast, and dinner each evening at a selection of the finest restaurants.

Make Your African Adventure Reservations Today!

Send to: Ohio State Medical Association
600 South High Street
Columbus, Ohio 43215

Enclosed is my check for $_____($100 per person), as deposit.

Name _____

Home Address _____

City _____ State _____ Zip _____

Area Code _____ Phone _____

A Non-Regimented INTRAV Deluxe Adventure

THE OHIO STATE Medical Association Cancer Education Series*

The Case for Conservative Management of Cancer

Frank Batley, M.B., Ch.B.

My interest in this subject began when I read a paper by Park and Lees in 1951 which stated that they could find no proof that the survival rate of patients with carcinoma of the breast had been improved by any form of therapy by more than 5%.[1] Indeed, they found no proof that the survival rate had been improved at all, but felt that a 5% improvement in survival could have occurred and would not be demonstrable by their studies.

Carcinoma of the Breast

I had been trained as a radiotherapist in Manchester, England believing in the use of postoperative radiotherapy for carcinoma of the breast to regional areas such as the internal mammary, supraclavicular, and high axillary nodes. This had become an established method of treatment, but a controlled series initiated in Manchester in 1950 and completed in 1956 showed no improvement in survival with postoperative radiation. The controls were followed and treated only if recurrence occurred, thus they were saved the discomfort and occasional complications of radiation therapy. However, the study did little to diminish the general use of postoperative radiation for carcinoma of the breast since traditions die slowly and it is easier for physicians to recommend treatment than a wait-and-see approach.

For over 20 years, I have not given postoperative radiation after radical mastectomy until recurrence appeared. It has been difficult to persuade referring physicians to accept this approach, but it is accepted more readily now since chemotherapy is used. One wonders how long it will take for the concept of more conservative surgery and more conservative use of chemotherapy to be accepted.

Aggressive treatment of cancer may not always be the best approach. In Richard Gordon's admittedly comic fiction, *Doctor in the House,* the author, an anesthesiologist, strung together a number of almost factual situations into a commentary on the behavior of medical students and their teachers. One remembers Sir Lancelot, the Chairman of Surgery at St. Swithin's Hospital, who spent all of his professional life developing an operation for

Dr. Batley, Columbus, Director of Radiation Therapy, The Ohio State University Hospitals; Professor of Radiology, The Ohio State University College of Medicine; and Member, OSMA Committee on Cancer.
Submitted September 11, 1978.

The Journal is pleased to publish this series through the cooperation of the OSMA Committee on Cancer and the American Cancer Society, Ohio Division, Inc.

cancer of the pancreas and traveled widely describing the operation and its results. When Sir Lancelot suddenly disappeared from the hospital, it was subsequently learned that he had been found to have cancer of the pancreas and had retired to his country home, accompanied by several cases of Scotch whiskey, to live out his remaining months.

Carcinoma of the Larynx

More factual is the problem of the treatment of carcinoma of the larynx. Removal of any portion of the larynx, and particularly laryngectomy, results in considerable disability. Although laryngologists recognize that early carcinoma of the larynx can be treated with radiotherapy with excellent results, any supraglottic tumor usually is regarded as a surgical problem, and either a partial or total laryngectomy is performed. An interesting paper on the treatment of supraglottic cancer of the larynx from the Princess Margaret Hospital in Toronto indicates the futility of striving for 100% cure of such cancers.[2] The authors demonstrate a 48% survival rate for supraglottic carcinoma of the larynx treated with radiation therapy. Some failures were due to local recurrence, which might not have occurred with surgical treatment. However, because a significant proportion of their patients died of intercurrent disease not related to their cancer, and some of distant metastases, elimination of failures due to local recurrence would not improve the survival rate by more than 8%. Elimination of failures due to nodal metastases improved the survival rate by only another 8%. Of course, adding the 8% of local recurrence plus 8% of nodal metastases which might be eliminated by surgery gives an improvement of 16% which is significant but assumes that surgical treatment never fails. Since we know that surgery sometimes is not successful, this possible improvement in survival would be less than 16%.

Distant Metastases

Finally, if distant metastases could be controlled by chemotherapy, the overall survival rate would increase from 64% to 71%. Each of these increments is about 8% and this degree of difference is difficult to be documented by controlled clinical trials. This makes it appear likely that cancer therapy often is determined by fashion and enthusiasm, rather than by science. However, what of the promise of chemotherapy with new agents appearing every few months with the potential for controlling distant metastases? For chemotherapy to be effective, it must be given in high doses which can be very toxic. It is necessary that any patients receiving anything other than homeopathic doses of chemotherapy be thoroughly investigated so that their renal, hepatic, and hematopoietic functions are able to tolerate treatment. Along with this general medical evaluation, it is customary to carry out investigations to determine the extent of the metastases. This is a sensible approach. These investigations are costly and often require hospitalization.

Patients referred for palliative radiation therapy are subjected to a minimum of diagnostic procedures since we need investigate only the symptomatic areas. Other areas will be treated as they become symptomatic, and chemotherapy to prevent metastases might not be successful. Perhaps this is not the most modern or popular approach, but it is certainly the least expensive. But, I hear you cry, what of the need for research, and for clinical trials of chemotherapy and radiation therapy? Obviously such studies should be done. My plea is that the clinical trials should be carefully controlled, with emphasis on the "control." Many studies fail as communication becomes difficult.

I have chosen breast and larynx cancer as examples because I can examine these regions as well as the surgeons and then compare their findings and results with mine. Such carcinomas as those of the bowel and bladder need a surgeon's skills to determine the extent of the disease, which places others with hopes of challenging their opinions at a disadvantage. Even so, I believe that if it were possible to compare conservative management with aggressive treatment, the suggestions I propose herein might still be valid.

We all strive for improvement. Yet I remember a quotation from an anonymous physician, who wrote in 1810 opposing some medical reform, "Before your proposed reform can be accomplished, physic must be made more perfect, doctors more honest, statesmen even more enlightened, and the bulk of mankind much wiser and better than they are at present, or have ever been, or are likely to become in our time."

Conclusion

This is not intended to be an advocacy of therapeutic nihilism. The important initial decision with a case of carcinoma is whether to treat radically or palliatively. Radical treatment justifies some risks of morbidity and deformity, but it should be chosen only if there is a reasonable chance of cure. In my opinion, less aggressive procedures often will give the same survival rate. For instance, although I advise against postoperative radiation for carcinoma of the breast after radical mastectomy, there is ample evidence that small carcinomas can be well-controlled by radiation alone, and larger ones with local surgery and radiation. Indeed, with advanced local disease, radiation alone or prior to surgery is mandatory.

When a cancer is incurable, then palliative treatment should be carefully tailored to the patient's symptoms so as to cause minimal side-effects. The decisions as to when to give palliative therapy are more difficult than for radical therapy. New agents and combinations of treatment are justifiable only under strictly controlled conditions.

References

1. Park WW, Lees JC: The absolute curability of cancer of the breast. *Surg Gynecol Obstet* **93**:129-152, 1951.
2. Neiderer J, Hawkins NV, Rider WD, et al: Failure analysis of radical radiation therapy of supraglottic laryngeal carcinoma. *Int J Radiat Biol* **2**:621-629, 1976. ☆☆☆

THE OHIO STATE Medical Association Obituaries

VIRGIL H. KEMPER, M.D., Dayton; Emory University School of Medicine, Atlanta, 1928; age 81; died August 28; member OSMA and AMA.

CLARENCE G. PAISLEY, M.D., Loudonville; Ohio State University College of Medicine, 1938; age 68; died August 7; member OSMA and AMA.

THOMAS F. ROSS, M.D., Alexandria; Faculty of Medicine, University of Edinburgh, Scotland, 1931; age 74; died July 7; member OSMA and AMA.

ALICE RUPP, M.D., Cleveland; University of Minnesota Medical School, Minneapolis, 1928; age 80; died July 25; member OSMA and AMA.

WALTER C. SCHEIDT, M.D., Van Wert; Ohio State University College of Medicine, 1929; age 75; died August 9.

County Society Roster Changes

Editor's Note.— *The following counties have submitted changes since the "Roster of County Society Officers, Executive Directors, and Meeting Dates" was printed in The Journal. (See Vol. 74, No. 4, April 1978, page 247.) All changes are noted in ITALIC type.*—**L.A.P.**

BUTLER: *Jack L. Harris, M.D., President, 3002 McGee Ave., Middletown 45042; Gilbert J. Gordon, M.D., Secretary-Treasurer, 3925 Roosevelt Blvd., Suite C, Middletown 45042; Mrs. Joan Williams, Executive Secretary, P.O. Box 3216, Hamilton 45013,* (513) 893-1410. Fourth Wednesday, September-May except December.

CUYAHOGA: *Robert J. White, M.D., Ph.D., President, Cleveland Metropolitan General Hospital, Cleveland 44109; Roland D. Carlson, M.D., Secretary-Treasurer, 29001 Cedar Rd., Lyndhurst 44124;* Robert A. Lang, Ph.D., Executive Director, 10525 Carnegie Ave., Cleveland 44106, (216) 231-3500.

GREENE: Priyakant K. Desai, M.D., President, 1142 N. Monroe Dr., Xenia 45385; Fang Chi Huang, M.D., Secretary-Treasurer, 1337 Hanes Rd., Xenia 45385; Mrs. Virginia Jones, Executive Secretary, *761 Buckskin Trail, Xenia 45385, (513) 376-3783.*

HAMILTON: *John E. Albers, M.D., President, 2350 Auburn Ave., Suite 27, Cincinnati 45219; Donald I. Radin, M.D., Secretary, 826 Swifton Ctr., Cincinnati 45237;* William J. Galligan, Executive Secretary, 320 Broadway, Cincinnati 45202, (513) 721-2345. Second Tuesday except August.

LAKE: Roy E. Ronke, Jr., M.D., President, *7110 Sandpiper Court, Painesville 44077;* Armin J. Green, M.D., Secretary, *8224 Mentor Ave., Mentor 44060;* Mrs. Marge McLaren, Executive Secretary, 7408 Cadle Ave., Mentor 44060, (216) 255-2233.

LICKING: John J. Winsch, M.D., President, 399 E. Main St., Newark 43055; Claude R. Rousseau, M.D., Secretary, 155 McMillen Dr., Newark 43055; *Ms. Lindsay Wagenheim, Executive Secretary,* 1320 W. Main St., Newark 43055, (614) 344-0331, Ext. 394. Fourth Tuesday except June, July, August and December.

MARION: *Pavanender Gupta, M.D., President, Marion General Hospital, McKinley Park Dr., Marion 43302; Edwin G. Davy, M.D., Secretary-Treasurer, Marion General Hospital, McKinley Park Dr., Marion 43302.* First Tuesday, September through May.

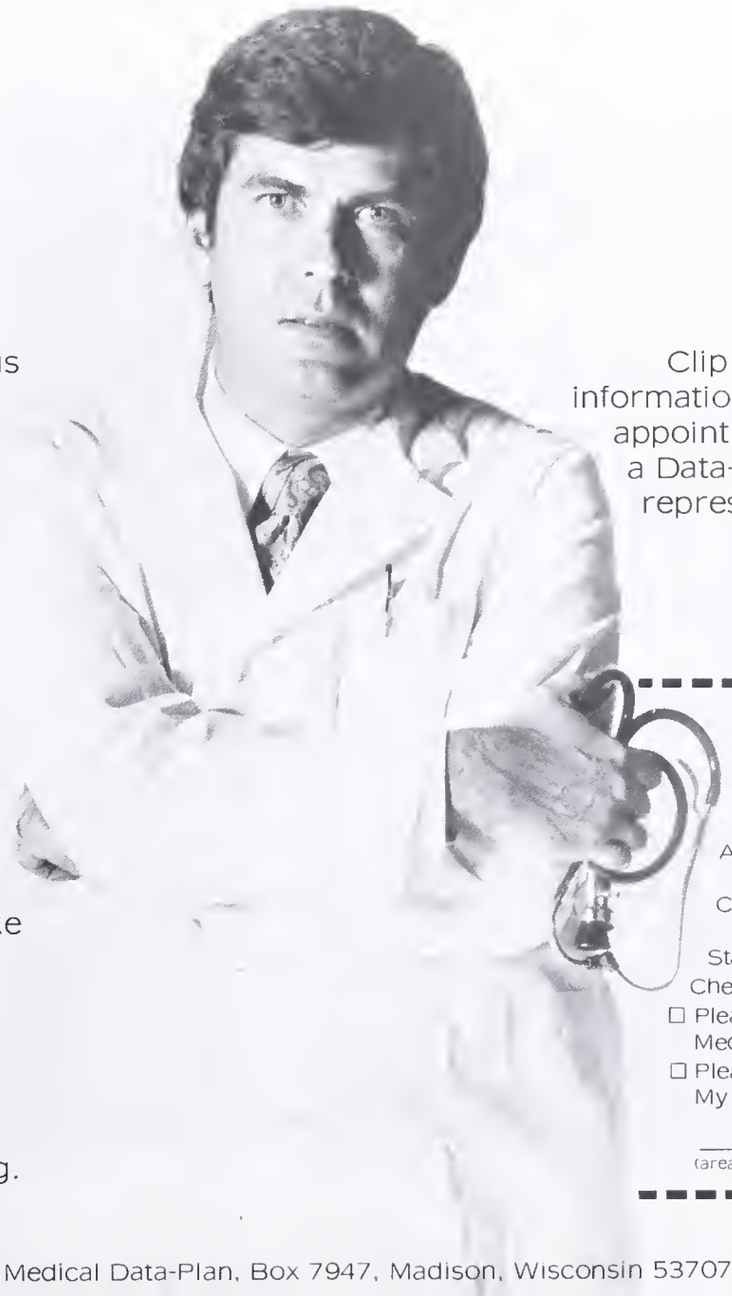
MONTGOMERY: Herman I. Abromowitz, M.D., President, 226 Troy St., Dayton 45404; Samuel A. Laneve, M.D., Secretary, 5752 Hither Green, Dayton 45429; Earl E. Shelton, Executive Director, *40 S. Perry St., Dayton 45402, (513) 223-1431.* Fourth Thursday except July and August.

PERRY: Alfredo Cruz, M.D., President, 203 N. Main St., New Lexington 43764; *Sydney N. Lord, M.D., Secretary-Treasurer, E. Main St., Somerset 43783.*

WYANDOT: Nasser J. Zohoury, M.D., President, 132 E. Wyandot, Upper Sandusky 43351; Cecilio V. Delgra, M.D., *Secretary-Treasurer, 110 S. Patterson St., Carey 43316.* Second Tuesday.

Medical Data-Plan®

We're not offering you just a computerized billing system. We're offering you a way to plan the future of your practice.



Medical Data-Plan is a computerized system for getting bills out, processing insurance forms, speeding up cash flow and improving collections.

It also gives you the information you need to plan the future of your practice . . . 3 years, 5 years, 10 years from now.

Based on a steady flow of accurate, timely computer reports, your business manager can make sound recommendations on personnel, equipment, materials, facilities and more. Medical Data-Plan can show you what your practice has been doing—and what it should be doing.

Clip this coupon to receive information or to arrange an appointment with a Data-Plan representative.

Data-Plan

OM

Medical Data-Plan
Box 7947, Madison, Wisconsin 53707

Name _____

Address _____

City _____

State _____ Zip _____

Check one or both boxes below:

☐ Please mail me more information about Medical Data-Plan.

☐ Please have a representative contact me. My phone number is:

_____
(area code) (number)

Medical Data-Plan, Box 7947, Madison, Wisconsin 53707

The Ohio State Medical Association New Members

BUTLER (Hamilton)
Jeff A. Cianchetti
Daniel Hart II

CLERMONT
Bienvenido Sy Lee, Batavia
Mary A. Lee, Goshen

CUYAHOGA
(Cleveland unless noted)
Carl A. Culley, Jr.
Stephen H. Lacey
Juan Rendon,
Schenectady, New York
B. Timothy Schaeffer

ERIE (Huron)
Manohara Gupta
Gwang O. Kim
Raj N. Ravindra

FAIRFIELD (Lancaster)
Paul Ruff

FRANKLIN (Columbus)
John A. Distler
Donald T. Evert
Susan Lee Hubbell
John B. Krupko
Lawrence E. Lohman
Wong G. Song
Mary Florence Vaeth
V. Rao Yeleti

GREENE (Xenia)
Al Batata

GUERNSEY (Cambridge)
Ashfaq H. Siddique

HAMILTON (Cincinnati)
John B. Clark
Bradford E. Colen
John S. Held
Irving Kohn
Conn McConnell
Richard H. Skurow
David P. Slaughter
Thomas O. Steedle
John S. Supance

LICKING (Newark)
Charles J. Marty

LORAIN (Vermilion)
Muhammad R. Chohan

LUCAS (Toledo unless noted)
Debidas Banerjee
Paul M. Clark
Joachim A. Dressler, Sylvania
Kyle Frederick Fort

TREAT THE SYMPTOMS IN THE GERIATRIC PATIENT

APATHY • IRRITABILITY
FORGETFULNESS • CONFUSION



Cerebro-Nicin® CAPSULES

A GENTLE CEREBRAL STIMULANT & VASODILATOR FOR GERIATRIC PATIENTS

Each CEREBRO-NICIN capsule contains:
Pentylenetetrazole .....100 mg. • Nicotinic Acid ...100 mg.
Ascorbic Acid .....100 mg. • Thiamine HCl .....25 mg.
l-Glutamic Acid .....50 mg. • Niacinamide .....5 mg.
Riboflavin .....2 mg. • Pyridoxine HCl .....3 mg.
AVAILABLE: Bottles 100, 500, 1000
SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and abdominal cramps. The reaction is usually transient.
INDICATIONS: As a cerebral stimulant and vasodilator.
RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.
WARNING: Overdosage may cause muscle tremor and convulsions.
CONTRAINDICATIONS: Epilepsy or low convulsive threshold.
CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

Write for literature and samples . . .
BROWN THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057

Khalid Hameed, Sylvania
Robert R. Hazelrigg
Hollis W. Merrick III
Madhukar Shah
Willi Sternfeld
Clark D. Weidaw
Irwin J. Weinfeld

MAHONING (Youngstown)
Nader Afroos

MARION (Marion)
K. David Kang
Narayanan Ponnusamy

MEDINA (Medina unless noted)
Chu Tsai Cheng
Agripino Carpio Gonzales, Brunswick
Mila Galang Gonzales, Brunswick
Shou Chao Ho

Jeffrey A. Kase
Urmila J. Patel, Brunswick
Leonard J. Torok

MONTGOMERY (Dayton)
Barbara Ann Beeler
James A. Bruce
Michael H. Butan
Aftab A. Butt
Patrocino Gaela Cruz
John D. Davis
Ramesh C. Gupta
Joseph E. Olszewski
Felino Tordilla
David A. Westbrook

MORROW (Cardington)
William K. Lee

PORTAGE (Kent)
Jim Chae

RICHLAND (Mansfield)
Michael D. Gunzenhaeuser
Terry L. Weston

SUMMIT (Akron unless noted)
Dennis A. Davis
Duane L. Donovan
Richard J. Flaksman
William H. Ginther
Earl T. Hoffman, Barberton
John F. Jacobs, Jr.
Jack G. Jones
Jeffrey J. Klein
Steven Kutnick
Gary D. Lichten
Robert E. Norman

WASHINGTON (Marietta)
Cheng Long Kuo

WOOD (Rossford)
Zubeida Moorjani

COLD FEET
LEG CRAMPS
TINNITUS
DISCOMFORT ON STANDING



LIPO-NICIN
A PERIPHERAL VASODILATOR

IMMEDIATE or GRADUAL
nicotinic acid therapy

IMMEDIATE RELEASE

LIPO-NICIN/100 mg.
Each blue tablet contains:
Nicotinic Acid .....100 mg.
Niacinamide ..... 75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .. 25 mg.
Riboflavin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6).. 10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500, 1000.

LIPO-NICIN/250 mg.
Each yellow tablet contains:
Nicotinic Acid .....250 mg.
Niacinamide ..... 75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .. 25 mg.
Riboflavin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6).. 10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500, 1000.

GRADUAL RELEASE

LIPO-NICIN/300 mg.
Each time-release capsule contains:
Nicotinic Acid .....300 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (H-1) .. 25 mg.
Riboflavin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6).. 10 mg.
In a special base of prolonged therapeutic effect.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient. Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur. Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

BROWN THE BROWN PHARMACEUTICAL CO., INC. 2500 West Sixth Street, Los Angeles, California 90057
Write for Literature and Samples
REFER TO PDR

HOMEOWNERS/FAMILY AUTOMOBILE

PACKAGE POLICY



The Reason You Should Switch to PICO

PICO has combined Homeowners and Family Automobile insurance coverages in one convenient package policy. . .at a savings over PICO's already low rates.

Purchase this package policy at the renewal date of either your homeowners or automobile coverage. The remaining coverage will be activated upon expiration of your current policy.

PICO's convenient, low-cost Homeowners and Family Automobile Package Policy. The latest in a series of innovative insurance services for members of the OSMA.

PICO. Formed by physicians, to serve physicians.

Physicians Insurance Company of Ohio
6100 Channingway Boulevard
Columbus, Ohio 43227

For the name of PICO's authorized agency in your area.
telephone (toll-free) 1-800-252-7515

THE OHIO STATE Medical Association News

AMA Grants One-Year Dues Reduction for Young Physicians

The House of Delegates of the American Medical Association has voted a 50%, one-year reduction in AMA dues for physicians first entering practice. Adopted at the Association's 1978 Annual Meeting, the reduction means that physicians in their first year of practice will be paying dues in the amount of $125, as contrasted with the $250 regular dues and the $35 paid by housestaff. The membership gain resulting from the dues cut is expected to reach almost 5,000 in five years.

In a report, the AMA Board of Trustees cited a survey which indicated that the $250 dues, rather than any lack of awareness of AMA activities, was the major obstacle to new-practitioner membership. The report noted that: "Ninety-three percent of nonmember students, 85% of nonmember residents, and 88% of nonmember practicing physicians have specific perceptions of what the AMA does as an organization." On the other hand, only 31% of the residents surveyed (members and nonmembers) said they would sign up at the $250 rate, as compared with 42% at the $125 rate.

The dues reduction should stimulate retention of housestaff and students who have increasingly poured into the AMA since its doors opened to them in 1972 and 1973 respectively. Their combined dues-paying membership jumped from 3,000 in 1973 to 28,094 in 1977.

Cancer Society Plans "Great American Smokeout"

The American Cancer Society has proclaimed November 16 as the day of the national "Great American Smokeout" a day to stop smoking. Three out of every ten smokers either stopped or reduced the number of cigarettes smoked during last year's "Smokeout."

The American Cancer Society notes that lung cancer is the single most preventable cancer known to man. If the American public gave up smoking, 80% of all lung cancers would never occur. Consider these statistics when applied to Ohio alone, where there are over 3.5 million smokers.

According to the Society, cigarette smoking has decreased in this country in recent years. A survey taken in 1964 showed that 52% of American men over the age of 21 were cigarette smokers. In 1975, that figure stood at 39%. The figures for women were 34% in 1964 and 29% in 1975.

Although women used to feel safe from lung cancer because the death rate was low for women compared with that for men, this picture is beginning to change alarmingly. The female lung cancer death rate has doubled in the past ten years. While female death rates from lung cancer were once as low as one-sixth the rate for men, they are now one-fourth the death rate for men and threatening to catch up.

More information regarding the "Great American Smokeout" is available from the American Cancer Society, Ohio Division, Inc., 1367 East 6th Street, Cleveland, Ohio 44144, telephone: 216/771-6700. The officers of the Society are Thomas D. Stevenson, M.D., Delaware, president; Robert L. Westerheide, M.D., Mt. Vernon, vice president; and John J. Newton, M.D., Sylvania, secretary.

Cleveland Sponsors New Course: "English as a Second Language"

The Academy of Medicine of Cleveland has cosponsored the pilot program to assist physicians whose native language is not English gain practical help in English pronunciation. Entitled "English as a Second Language," the program was developed by the Academy in cooperation with Cuyahoga Community College and the American Medical Association.

Participants reviewed the more than 40 basic sounds used in American English pronunciation, including vowel combinations and consonants. Then they broke into small groups according to native language, where each physician received individual instruction. The final exercise was the presentation of an extemporaneous speech. Following the course, the participants each received nine audio cassettes for use with a text during home study and practice.

The program was organized through the efforts of the Academy's Foreign Medical Graduates Committee, chaired by Felino V. Barnes, M.D. "English as a Second Language" has been added to the list of courses sponsored by the AMA through its Speakers and Leadership Division.

Certificate-of-Need Appeal Won by Radiologist

A New Jersey radiologist has won an appeal of a decision by the state commissioner of health that he would need a certificate of need to install a CT scanner in his private office practice. According to the *Bulletin* of the American College of Radiology (August 1978), Albert P. Marsh, M.D., Vineland, appealed the decision of Commissioner Joanne E. Finley, M.D., who had concluded that Dr. Marsh's plans to buy a CT unit con-

(News continued on next page)

News *(continued from page 661)*

stituted "the operation of a health care facility subject to the certificate of need requirement of the Health Care Facilities Planning Act."

On appeal, Dr. Marsh contended the commissioner's authority to issue a certificate of need does not extend to a physician's private practice. In addition, he stated that the Act applies only to institutional facilities and does not authorize the commissioner to regulate the services provided by a physician in his private practice.

In reversing Dr. Finley's decision, the Court said: "the Act as adopted clearly evinces its objective of control over institutions such as hospitals and like facilities" and does not include "a physician's private practice" regarding requirements for a certificate of need.

FDA Schedules Conference on Patient Package Inserts

The Food and Drug Administration (FDA) is sponsoring a conference in December on how to choose contents and methods of presentation for patient package inserts (PPIs). Currently, the FDA requires that patient information be distributed with estrogens, oral contraceptives, and isoproterenol inhalation products. In the near future, it will announce its intent to eventually require PPIs for a wide range of drug products on the market. The first group of PPIs will be drafted under contract for a few selected drugs.

In order to gather advice from a variety of perspectives regarding the contents and methods of presentation for PPIs, the FDA is sponsoring a conference December 11-12 at the Shoreham Americana Hotel, Washington D.C. Health professionals, consumers, and other interested parties are encouraged to provide input at this conference. There is no charge for registration; but in order to arrange workshops, preregistration is encouraged. Requests for information and registration forms should be directed to: Ms. Ann Myers, HFD-107, Food and Drug Administration, 5600 Fishers Lane, Rockville, Maryland 20857, phone: 301/443-6004.

Saccharin Restrictions Not Needed

The American Diabetes Association (ADA) has concluded that, based on evidence available as of early 1978, there appears to be little justification for placing further governmental restrictions on the use of saccharin at the present time. The Association's Select Committee on Sugar Substitutes examined all of the presently published findings on human epidemological studies, mutagenicity testing, and animal feeding experiments with regard to the possible cancer-inducing properties of saccharin. This committee was chaired by Ronald K. Kalkhoff, M.D., Professor of Medicine and Chief, Endocrine-Metabolic Section, Medical College of Wisconsin.

This committee was formed following the April 1977 proposal by the Food and Drug Administration to ban saccharin as a food additive. Congress reacted to the intense public response to this proposal by initiating the present 18-month moratorium, and the American Diabetes Association began its review of all relevant scientific data because the quality of life of millions of diabetics has benefited from the availability of saccharin.

Norbert Freinkel, M.D., President of the ADA when the position statement of the Associaton on saccharin was formulated, said:

> Surveillance of new information by the American Diabetes Association will continue, but much more research of a broader scope and greater detail will be needed to modify the conclusions we have reached on the basis of the facts now available to us.

More Young Alcoholics

The largest survey ever made of recovered alcoholics shows a nearly 50% increase since 1974 in the percentage of people under 30 years of age in Alcoholics Anonymous (AA). The world-wide survey, fourth in a series made every three years, also revealed that 32% of the members coming to AA today are women. More than 17,000 AA members participated in the study, which also indicated:

★ More young people and women indicated an addiction to drugs in addition to alcohol. Of the under-30-year-old members, 43% said they also were addicted to another drug compared to 18% for the total sample. Twice as many women as men indicated multiple-addiction upon entering AA.

★ Statistical analyses of respondents showed that an alcoholic who tries the program for 90 days has a 50% chance of staying sober for the next year; a member with one-to-five years' sobriety has an 80% likelihood of remaining active in the association and extending his sobriety for another year; and a member with more than five years' sobriety has a 90% chance of both not drinking and remaining in AA for another year.

Physicians and Oil Company Publish Auto Accident Booklet

The American College of Emergency Physicians has cooperated with the Shell Oil Company to produce a booklet entitled "The Accident Book." The 15th in the "Answer Book" series produced by Shell Oil Company, this booklet discusses the activities of people who happen upon the scene of an accident. Highlights include where to park, basic first-aid procedures, and contents of an accident kit for a car.

Karl G. Mangold, M.D., President of the American College of Emergency Physicians, hailed the booklet's publication, stating: "Our members specialize in treating the victims of accidents. We're happy to participate in any program that will improve the care these victims receive before they get to us."

Shell Oil Company has printed over 37 million copies of "The Answer Book" for distribution through their network of service stations and as enclosures in major national magazines.

Case Experiments With Continuing Medical Education Via Cable TV

Case Western Reserve University School of Medicine is active in the first experiment to use cable television to transmit continuing medical education courses. Since April 19, subscribers of some cable television in Greater Cleveland, Dayton, and Springfield have been receiving at-home courses in medical advances covering such topics as adjusting drug dosage, preventing and treating intestinal infections, and the medical and social significance of tattooing.

Entitled "Medicine Today," the program's basic format consists of therapeutics conferences, which focus on new advances in drug therapy; and medical grand rounds, which include patient-oriented discussion among the audience usually comprised of about 250 of the medical school faculty.

"Medicine Today" is sponsored by Case Western Reserve's Department of Medicine, the Office of the Dean of the School of Medicine, and the Medical Council of the University Hospitals of Cleveland, Inc. W. Leigh Thompson, M.D., is the editor of the program, which has the endorsement of the Cleveland Academy of Medicine.

Rural Health Conference Scheduled

The 32nd National Conference on Rural Health has been scheduled for April 18-21, 1979 in St. Paul, Minnesota. Twelve health and medically oriented organizations have joined with the AMA to sponsor this conference which will feature programs examining all aspects of the delivery of health care and related matters. Continuing medical education courses will focus on the illness, injuries, and medical socioeconomics encountered by medical personnel who serve rural populations.

Motorcycle Crash Deaths on Rise

The American Medical Association has pointed out that motorcycle crash deaths are increasing sharply in the wake of at least 23 states overturning laws requiring riders to wear safety helmets. With increased helmet usage in the 1960s, head-related fatalities among motorcyclists dropped 40%. But the Highway Safety Act of 1976 removed the authority of the U.S. Secretary of Transportation to require mandatory use of helmets. Consequently, many states repealed their helmet laws; and fatalities have now risen precipitously to some 4,000 deaths each year.

Opponents of mandatory helmet laws have maintained that helmets restrict vision and impair hearing. Neither contention has been found valid, the AMA declared. The full-facial coverage helmet allows peripheral vision of 180 degrees, well above the 140 degrees that most states require for licensure to drive an automobile. The AMA also noted that there is no scientific evidence to support the contention that the helmet dangerously impairs hearing, pointing out that the loud noise of the motorcycle itself blocks out most other sound. About 80% of motorcycle crash injuries are to the head, and the chance of being killed is two-thirds greater for the unhelmeted cyclist, the AMA said.

A copy of the AMA conference report entitled "Head Protection for the Cyclist" can be obtained without charge from the AMA, 535 N. Dearborn Street, Chicago, Illinois 60610.

Medicare Payments Increase

Medicare Part B payments to physicians have been increased by 5% retroactive to July 1. The increase results from an annual review required by law to ensure that Medicare reimbursement of physicians' fees reflects changes in the economy. The fee reimbursement schedule does not limit the amount a physician may charge a patient but only the amount Medicare will pay.

In addition, the Department of Health, Education and Welfare will limit Medicare and Medicaid payments for lab tests and medical equipment to "the lowest prices at which they are widely and consistently available in a locality," according to final regulations effective July 26. Until this date, higher payments were allowed, based on the going rate charged in the community or as priced by the laboratory or supplier.

HEW Secretary Joseph Califano explained: "Placing these limitations on Medicare payments should stimulate substantially increased price competition among suppliers in the medical field."

Initially, the payment limit will apply to the purchase of hospital beds and wheelchairs for home use and to the 12 most commonly performed laboratory services in any setting.

7th Edition *Profile of Medical Practice* Available From AMA

The seventh annual edition of the American Medical Association's *Profile of Medical Practice* is off the press, with 283 pages of new information on the economics of medical practice in the United States today. Most of the information is based on the AMA's 11th Periodic Survey of Physicians, in which a cross-section of doctors are asked many questions regarding office finances, working hours, and other aspects of medical management.

Among the many new findings of the AMA reference book are:

★ Effects of the malpractice crisis of 1975 are still being felt by U.S. physicians and their patients. Almost half of doctors in office practice reported that they have increased their fees to cover rising premiums for malpractice insurance. And more than one-third of the doctors said they are practicing defensive medicine— ordering more tests and procedures to protect themselves against possible legal action.

★ Patterns in the geographic location of physicians

(News continued on next page)

News *(continued from page 663)*

continue to change, with many of the states in the Northeast and North Central regions of the country experiencing only average or below average rates of growth in physician-population ratios. States which have been traditionally underserved are experiencing more rapid rates of increases in physicians than are states in the balance of the country.

★ Since 1975, the rate of increase of physicians' fees, as measured by the consumer price index, have been declining, to 9.2% in 1977.

★ For the typical physician, practice expenses increased at a compound rate of growth of 10.4%, 1969-1976, while net income from medical practice increased at a rate of 6% over the same period.

★ On Dec. 31, 1976, the mean age of male physicians with known addresses was 46.3 years while the mean age of women physicians was 42.4 years. Almost 40% of women physicians were less than 35 years of age.

★ The average doctor in office practice worked 47.2 weeks in 1975. The typical physician practiced medicine 52.2 hours per week in 1976, as compared with 51.8 in 1975, and 49.9 hours in 1974.

★ The average physician in 1976 was seeing more patients— 128.5 per week— as compared with 126.5 in 1976 and 125.8 in 1974.

Profile of Medical Practice 1978 is a companion book to the AMA's *Socioeconomic Issues of Health 1978*, issued earlier this year. The two books provide health professionals, policy-makers, and researchers with analyses of issues in health care delivery as well as with current health care data.

Profile of Medical Practice 1978 is available from Order Department OP-52, American Medical Association, P.O. Box 821, Monroe, Wisconsin 53566. Individual copies are $5.

Journal Advertisers

Brown Pharmaceutical Company, Inc....601, 658, 659
Burroughs Wellcome Co...604, 646

Crutcher Antique Show.....645

Harding Hospital.....641
Hempel Financial Corporation 609

Immke Circle Leasing.....652
International Travel Advisors 627, 653

Lilly, Eli and Company.....611

Mead Johnson Pharmaceutical Division.....613, 614
Medical Protective Company 651
Menendian Carpets.....600

Ohio Medical Indemnity.....605
Ohio State Medical Association 616
Ohio State University College of Medicine...638, 650

PBP Data Systems.....657
Pennwalt Prescription Products 632, 633
Physicians Insurance Company of Ohio, Inc.....660
PICO Life.....628
Practice Productivity.....666

Roche Laboratories, Div. of Hoffmann-LaRoche, Inc. ....597, 598, Cover 2, Cover 3, Cover 4

Smith, Kline and French Labs. 634, 635
Stanley H. Kaplan Educational Center 600
S-Tek 603

Turner & Shepard, Inc.....621

Upjohn Pharmaceutical Company.....622

Wendt-Bristol Company 642
Windsor Hospital.....612

Occupational Medicine Residency

The University of Cincinnati Medical Center has begun a miniresidency program in occupational medicine. Thirty-two physicians from Indonesia, Argentina, Canada, and the United States began the program with three weeks of intensive work at the Medical Center; this will be followed by a continuing program of training over the next two years in what is thought to be the only program of its kind in this field. Sidney I. Lerner, M.D., Associate Professor of Environmental Health, is director of the program which includes such topics as clinical and administrative occupational medicine, biostatistics and epidemiology, environment, and industrial hygiene technology.

Indiana Physician Contesting Hospital's Insurance Requirement

A hospital's rule that physicians must carry medical malpractice insurance, upheld previously by a county court in Indiana, is being contested by the physician in a case before the Indiana Court of Appeals. The Indiana Hospital Association has filed an amicus curiae brief before the appeals court on behalf of Fayette Memorial Hospital, Connersville. In Arizona, the state supreme court ruled last December that a hospital has the right to protect its interests by requiring staff physicians to carry malpractice insurance.

AMA Publishes List of 1978-1979 Continuing Education Courses

The American Medical Association has published its annual listing of continuing education courses for physicians. The 24th such publication, the listing appears as a special issue of the September 8, 1978 *Journal of the American Medical Association (JAMA)*. This issue lists 8,795 courses offered by 1,576 institutions in 48 states, the District of Columbia, Puerto Rico, and the Virgin Islands during the period September 1, 1978 to August 31, 1979.

New Directory of Agencies Serving Visually Handicapped Persons

The American Foundation for the Blind has released the new edition of *Directory of Agencies Serving the Visually Handicapped in the U.S.* The publication's new format provides more complete, specific, and useful information about agencies and schools that offer direct services to visually handicapped persons. One section concentrates on low vision services, giving the hours, services, and low vision aids available from more than 100 agencies and clinics.

The directory is available from the Foundation's Publications Division, 15 West 16th Street, New York, New York 10011. The cost is $10 per copy. In addition, the low vision section is available as a reprint for $2 per copy.

OSMA Placement Service Ads

In order to promote retention in Ohio of physicians who trained in the State, ***The Journal***, in cooperation with the OSMA Department of Field Service, offers classified advertising listings at no charge to physicians-in-training desiring to practice in Ohio. Persons eligible for this service must be graduates of Ohio medical schools and/or persons who are completing an internship or residency program at an Ohio institution. They must also be currently in a medical training program or in the United States Armed Forces (or some other U.S. government service).

All classified ads will be printed anonymously by use of box numbers in a special classified ad section of ***The Journal***. Replies to the ads will be channeled through the Department of Field Service, which will assist in the location process. (Replies are otherwise confidential.) Ads will be printed as frequently as space permits. (See previous issues of ***The Journal*** for additional listings.)



INTERNIST: With cardiology subspecialty available September 1979. Diplomate of the Board of Internal Medicine. Eligible for the specialty board examination in cardiovascular disease in 1979. Prefers location in areas 2, 3, or 5 in community that is rural with metropolitan ties or suburban metropolitan with population of 50,000 to 500,000. Interested in group or institutional practice and part-time academic appointment. Contact Box P-32 c/o Ohio State Medical Journal.

INTERNIST: With gastroenterology subspecialty available July 1978. Passed specialty board examination June 1977. Desires location in areas 2, 3, 4 or 5 in suburban metropolitan or metropolitan community with population of 15,000 to 100,000. Interested in small group practice with part-time academic appointment, full-time academic appointment or governmental position. Contact Box P-21 c/o Ohio State Medical Journal.

PEDIATRICIAN: With adolescent medicine subspecialty available summer of 1979. Eligible for specialty board examination in July 1979. Looking for temporary position (1979-1980) in Cincinnati area; would consider permanent location there if situation very attractive. Contact Box P-33 c/o Ohio State Medical Journal.

INTERNIST: With endocrinology subspecialty available July 1979. Will take specialty board examination in September 1978. Desires location in areas 1 or 4 in metropolitan community with population of 50,000 to 1 million. Interested in small group practice and part-time academic appointment. Contact Box P-31 c/o Ohio State Medical Journal.

EMERGENCY PHYSICIAN: Available July 1979. Desires group practice in community that is rural with metropolitan ties with population of 15,000-50,000. Eligible for specialty board examination July 1979. Contact Box P-22 c/o Ohio State Medical Journal.

UROLOGIST: Available July 1979. Eligible for specialty board examination January 1979. Desires location in suburban metropolitan or metropolitan community with 50,000-500,000 population. Interested in solo practice or group practice of six or more members. Contact Box P-34 c/o Ohio State Medical Journal.

INTERNIST: Available July 1979. Eligible for specialty board examination in June 1979. Desires location in areas 1, 3, or 5 in suburban metropolitan community with population of 15,000-50,000. Interested in solo or group practice. Contact Box P-36 c/o Ohio State Medical Journal.

ORTHOPEDIC SURGEON: Available July 1979. Interested in group practice in community of 50,000-1 million people that is rural with metropolitan ties, suburban metropolitan or metropolitan or in an inner city setting. Eligible for specialty board examination in July 1980. Contact Box P-35 c/o Ohio State Medical Journal.

ANESTHESIOLOGIST: Currently available. Desires small group practice in metropolitan area with population 50,000-500,000. No preference as to area of state. Contact Box P-10 c/o Ohio State Medical Journal.

PSYCHIATRIST: Also general medicine. Available July 1978. Desires location in suburban metropolitan, metropolitan, or inner city community in areas 1, 4, or 5. Population 15,000-1-million. Very flexible as to type of practice. Eligible for specialty board examination July 1978. Contact Box P-6 c/o Ohio State Medical Journal.

INTERNIST: With pulmonary medicine sub-specialty. Available July 1978. Diplomate of Board of Internal Medicine. Eligible for specialty board examination in pulmonary medicine in 1978. Desires community that is suburban metropolitan or metropolitan with population of 15,000-1 million. Interested in group or industrial practice with part-time academic appointment. Contact Box P-26 c/o Ohio State Medical Journal.

SURGEON: General with vascular subspecialty available July 1979. Desires group practice in community that is rural with metropolitan ties, suburban metropolitan, metropolitan or inner city and over 15,000 population. Eligible for specialty board June 1978. Contact Box P-29 c/o Ohio State Medical Journal.

INTERNIST: Available July 1978. Desires location in community that is rural with metropolitan ties, suburban metropolitan, metropolitan or inner city and over 15,000 population. Eligible for specialty board June 1978. Prefers group/partnership but solo practice with guarantee will also be considered. Contact Box P-30 c/o Ohio State Medical Journal.

Practice Productivity Inc.

Cosponsored by the

Ohio State Medical Association

ONE DAY WORKSHOP

BUSINESS ESSENTIALS FOR A MEDICAL OFFICE

FOR YOUR MEDICAL OFFICE ASSISTANTS

8:45 a.m. to 5:00 p.m.

Oct. 17, 1978	Toledo	Sheraton-Westgate Inn
Oct. 18, 1978	Cleveland	Marriott Inn - Airport
Oct. 19, 1978	Akron	Tangier Restaurant
Oct. 24, 1978	Columbus	Marriott Inn
Oct. 25, 1978	Dayton	Imperial Crown Dayton
Oct. 26, 1978	Cincinnati	Marriott Inn
Oct. 31, 1978	Lima	Ramada Inn
Nov. 1, 1978	Canton	Sheraton Belden Inn
Nov. 2, 1978	Youngstown	Howard Johnson's Motor Lodge

OFFICE MANAGERS
RECEPTIONISTS
MEDICAL SECRETARIES
BOOKKEEPERS
INSURANCE CLERKS
NURSES

This program has been approved for Continuing Education Units by AAMA

TOPICS: Telephone Management, Appointment Scheduling, Medical Records, Personnel, Billing Systems and Collection, Insurance Claim Processing.

Practice Productivity Inc. is a national management consulting firm located in Atlanta whose only clients are physicians engaged in the private practice of medicine. Practice Productivity offers educational and motivational workshops in sound business concepts to physicians, medical office managers, and medical assistants. Practice Productivity also provides nation-wide individual consulting to physicians at their private practice.

For Further information, contact:
Duane M. Johnson, PhD, Executive Vice-President, Practice Productivity, Inc.

Registration Form

Name	Position	City Will Attend	Date Will Attend
1.			
2.			
3.			

Name of Practice: _____

Specialty: _____ Telephone: (_____) _____

Address: _____

City: _____ State: _____ Zip: _____

Full tuition fee of $ _____ is enclosed at $75 per registrant. Tuition includes course materials and luncheon and MUST ACCOMPANY THIS FORM. (There is a $10 handling fee deducted on all refunds for cancellations received at least one week in advance of course; no refund thereafter.)

Practice Productivity Inc.

2000 Clearview Avenue, Atlanta, Georgia 30340, Telephone (404) 455-7344 or Toll Free 800-241-6228

Classified Ads

Rates: $3 per line. Display classified: $5 per line. Minimum 3 lines per insertion. Ads measure 8 lines to the inch. Box number reply: Flat $5 charge in addition to line cost for up to and including three insertions. (Covers cost of mailing replies which are kept confidential.) Forms close the 10th day of the month preceding month of publication. Address all ads Attention: Classified Ad Department, ***The Journal.***

To assure prompt delivery, when replying to an advertisement over a ***Journal*** box number, address letters as follows: Box (insert number), c/o ***The Ohio State Medical Journal***, 600 South High Street, Columbus, Ohio 43215.

AVAILABLE FOR IMMEDIATE TRANSFER: A thirty-year internal medicine practice in the Doctors Building, Cincinnati, Ohio, due to sudden death of a highly respected physician. Fully equipped; well-qualified medical secretary to assist; large number of devoted, appreciative patients. Terms can be negotiated. Contact Alfred Katz: 513/721-5151.

INTERNISTS/FAMILY PRACTITIONERS: Needed to practice in Canton, Ohio, a metropolitan area of 400,000 persons convenient to Akron, Cleveland, and numerous recreational areas. Various practice opportunities exist in association with a 520-bed medical center affiliated with the rapidly growing Northeastern Ohio Universities College of Medicine. The hospital is also currently planning a $30 million program. Income potential is excellent. Contact Jerome Fladen, M.D., Timken Mercy Hospital, 2015 Twelfth Street, N.W., Canton, Ohio 44708, telephone: 216/489-1000.

GARFIELD HTS., OHIO: Immediate position available for full-time physician with background in emergency care, family practice, medicine, or surgery in our new emergency facility of 300-bed hospital with complete specialty backup. Paid vacations, malpractice and health insurance, plus pension plan. Contact: Victor Koludrovich, M.D., 12300 McCracken Rd., Garfield Hts., Ohio 44125, phone: 216/581-0500 or 524-7753.

FOR LEASE: 1,245 sq ft medical office suite in northwest Columbus, Ohio. Four examining rooms with water, private office, restroom, waiting, and reception areas. Off-street parking. $6.50 sq ft including utilities. Call Mr. Rausch: 614/451-0030.

STATE MENTAL HEALTH HOSPITAL SUPERINTENDENT: The Search Committee for Athens MH and MR Center is actively seeking applicants for the position of superintendent. We are looking for experienced applicants in hospital administration, public health, psychology, social work, psychiatric nursing or allied fields. Salary negotiable. Letters of application and resume should be sent to: John Angel, Staff Liaison Search Committee, District MH Office, Athens MH-MR Center, Athens, Ohio 45701, phone: 614/593-7751.

An Equal Opportunity Employer

CARDIOLOGIST WANTED: Northwest Ohio. Board certified or eligible to join a busy consulting practice. Performing echos, phonos, treadmill, VCG, Holter, and rehabilitation. Participate in three hospital consultation, C.C.U. and catheterization. Teaching position available. Salary negotiable. Reply to Box 838 c/o Ohio State Medical Journal.

FAMILY PRACTICE — RURAL PRACTICE: Northwest/central rural/agrarian community of 1200/1500 needs family practice physician. Practice could expand to cover 3000/3500 population area. No physician now practicing. Community will support. Major regional hospital within driving distance. Contact *ROBERT FLINT,* **MARION HOSPITAL, MARION, OHIO** 43302, phone: 614/387-8810 or 387-5442.

OB/GYN: Incorporated OB/GYN group seeking an additional member. Suburb of medium-size city, midwestern Ohio. Please send curriculum vitae and request for additional information to: Box 838 c/o Ohio State Medical Journal.

PEDIATRICIAN WANTED: For 47-man multispecialty group located in a prosperous Central Ohio community. Present Department includes four pediatricians providing 37,000 outpatient visits yearly. Attractive salary and unusual fringes, including retirement program; early partnership with no financial investment. Send C.V. or call collect to Albert N. May, M.D. or Bruce Dyer, Executive Director, F. C. Smith Clinic, 1040 Delaware Avenue, Marion, Ohio 43302, phone 614/387-0850.

OB/GYN: Lake County. Solid solo practice for 17 years. Fifteen minutes to downtown Cleveland. Office and all equipment available December 1. Leaving for military service. Rent, lease, or sale. Phone: 216/946-1000, 946-6132 or 946-8819.

PRACTICE - CLINIC - PRIMARY CARE: Ideal group practice location. Industrial, ranching community. Will sell inventory— appraised value—, building, land. Will introduce. Send curriculum vitae to: Robert C. Miller, M.D., 101 Parking Way, Lake Jackson, Texas 77566, phone: 713/297-2441.

RADIOLOGIST: 108-bed community hospital desires full-time radiologist to run department and expand services to include ultrasound, scans, and mammography. Reply Box 840 c/o Ohio State Medical Journal.

INDUSTRIAL PHYSICIAN: A challenging and exciting position available as staff M.D. for Marion Regional Health Services, Inc. in Marion, Ohio. We furnish complete occupational programs to include preemployment physicals, job injuries, and occupational hazzard evaluation to many small and moderate-sized plants in Central Ohio. We are anxious to expand into other areas, including preventive medicine, ecological medicine, environmental health, toxicology, and patient education. Marion is a pleasant, rural community of approximately 40,000 to 50,000 that serves as a headquarters for numerous manufacturers of heavy equipment, appliances, packing containers, pet foods, metal products, and agricultural commodities. Competitive salary with excellent fringe benefits including a pension and profit-sharing plan, life insurance, and medical benefits. No night or weekend calls. Board certification or industrial medical experience is not required. Contact Nelson H. Kraus, M.D., Medical Director of Marion Regional Health Services, Inc., 1142 Independence Ave., Marion, Ohio 43302, phone: 614/387-6466.

ATHENS: Emergency Department Physician practice available. Minimum guarantee/fee-for-service. Income $50,000-$65,000. Contact James Ginter, Regional Director, Physicians Placement Group, Inc., 931 Chatham Road, Columbus, Ohio 43221, or call 614/457-9761.

NEW MODERN HOUSE: Tortola, British Virgin Islands. Fully equipped for four persons. Vacation rental weekly, winter or summer. Maid service. Unparalleled situation and climate. Photographs available on request. Contact: Raynes, 105 West Princeton, Youngstown, Ohio 44507.

(Classified Ads continued on next page.)

AVAILABLE: Long-established physician's office for rental or property purchase. Excellent practice opportunity for general practitioner. Reply to: 329 Vassar Avenue, Elyria, Ohio 44035.

GENERAL PRACTICE PHYSICIAN WANTED: Office space available. $100,000 first-year potential. Northcentral Ohio, population area 25,000. Ideal environment, excellent sports, recreational facilities, boating nearby. Midway Cleveland-Toledo, 100 miles north Columbus. Modern 68-bed hospital. Good schools. Brochure on request. Write T. R. Ball, M.D., Box 309, Bellevue, Ohio 44811.

PEDIATRICIAN, OB-GYN, INTERNIST & SURGEON: Board-eligible or certified. Needed immediately for established multispecialty group in mid-Ohio community of 60,000, next to 500-bed hospital. Liberal payment and benefits. Contact: J. Harold King, M.D., 295 Glessner Ave., Mansfield, Ohio 44903, phone 419/525-1111.

MEDICAL DIRECTOR— OCCUPATIONAL HEALTH/PREVENTIVE MEDICINE: Ohio Bell Telephone Company has embarked on an expanded occupational health program and is seeking someone who is interested in participating in the organization's development and growth. This position is located at the company's headquarters in Cleveland. Internal medicine and/or occupational health background is helpful but not necessary; interest and desire is most important. Excellent fringe benefit package includes life, health, dental, and professional liability; pension; savings plan; paid vacations, etc. Salary commensurate with other industries and in keeping with background training and experience. Send curriculum vitae to G. H. Franck, M.D., Corporate Medical Director, Ohio Bell Telephone Company, 100 Erieview Plaza, Room 910, Cleveland, Ohio 44114.

An Equal Opportunity Affirmative-Action Employer

GENERAL MEDICAL OFFICES AVAILABLE FOR RENT: In Hartville, reportedly the fastest growing township in Ohio. New construction permitting individual furnishing. Physically attached to Cancer Center with diagnostic x-ray, laboratory, and pharmacy facilities. Contact George N. Swallon Agency, Canton, Ohio, 216/456-3495, or inquire of R. K. Loeffler, M.D., 650 South Prospect, Hartville, Ohio 44632.

WANTED
FULL-TIME MEDICAL DIRECTOR

The Fourth Ohio Area Professional Standards Review Council, a PSRO serving the ten counties in northwestern Ohio, announces a staff opening for a full-time Medical Director. The Medical Director will report to the Executive Committee and Board of Trustees on professional matters and to the Executive Director on administrative matters. In addition, the medical director will serve as an ex-officio member of standing and ad hoc professional committees of PSR Council.

Applicants should be committed to the concept of the PSRO program, be able to present views clearly to fellow physicians, and be willing to perform administrative duties in conjunction with other physician members and nonphysician staff (ie, be "team oriented"). Knowledge of utilization review, medical care evaluation procedures, and level-of-care guidelines is desirable. Travel in northwestern Ohio and evening meetings necessary. This is a full-time position, requiring an involvement per week of at least 40 hours.

Applicants should have adequate experience in the private practice of medicine and should be knowledgeable in the techniques of the various methods of professional review.

Maximum starting salary: $53,000 per year plus liberal fringe benefits.

Interested applicants should submit curriculum vitae to:

Richard A. Haynes
Executive Director
Fourth Ohio Area PSR Council
5600 Monroe, Bldg. B
Sylvania, Ohio 43560

NEW OFFICE SPACE: Available in rapidly growing area of Ohio, 25 miles west of Cleveland, one block from a newly expanded 400-bed hospital. Please call 216/322-3947 or 216/323-8458 for further information.

OB/GYN: Well-established busy OB/GYN practice in Northeast Ohio for sale. Grossing over $150,000 per year. Fully equipped office and three examining rooms with the latest OB/GYN equipment. Will introduce you to patients. Price and terms negotiable. If interested, call 216/257-7227, Mentor, Ohio.

FAMILY PRACTICE: Partners need associate in busy practice in fast-growing community. Southwest Ohio near city hospitals and medical schools. Write or call collect: G. K. Ohlhauser, M.D. or Thomas E. Fox, M.D., 309 Reading Road, Mason, Ohio 45040, phone 513/398-6010.

EMERGENCY MEDICINE: Ohio and western Pennsylvania. Occasional part-time or full-time work available. Excellent remuneration and flexible scheduling. Ohio or Pennsylvania license required. Contact: James Ginter, Regional Administrator, 931 Chatham Lane, Columbus, Ohio 43221, phone: 614/457-9761.

AMBULATORY CARE CENTER — EMERGENCY DEPARTMENT STAFF PHYSICIAN, ATHENS, OHIO: 20,000 annual patient visits. Flexible scheduling, minimum guarantee/monthly bonus, excellent fringes. Contact Eric Jenison, M.D., O'Bleness Memorial Hospital, Athens, Ohio 45701, or call toll-free 800/325-3982 for details.

LOOKING FOR A POSITION?
SEEKING AN ASSOCIATE?
Contact the OSMA Placement Service
600 S. High Street, Columbus 43215
Telephone: 614/228-6971

OPHTHALMOLOGIST: Board-certified eligible ophthalmologist sought to associate in an established practice. Major regional medical center consisting of 43 multispecialty physicans in northwest Ohio. Top salary and excellent fringe benefit program along with all corporate benefits. Please forward curriculum vitae, salary requirements to Box 837 c/o Ohio State Medical Journal.

MARION, OHIO: Excellent opportunities in Central Ohio. Existing and new, solo, partnerships, or association practices available and seeking physician support. Top compensation— reliable cross coverage. Exceptionally attractive, 225-bed, well-equipped regional medical center hospital within walking distance from offices. Industry and agriculture support city/45,000; county/65,000; and total trade area/250,000. Excellent schools and residential areas. Fifty-minute, easy drive to Columbus. Active need for—

FAMILY PRACTICE
INTERNAL MEDICINE
OTOLARYNGOLOGY
PEDIATRICS
INDUSTRIAL/OCCUPATIONAL
EMERGENCY MEDICINE

We are seeking either rural or city-oriented physicians. Send C.V. or contact— **ROBERT FLINT,** Marion General Hospital, **MARION, OHIO** 43302 — or call 614/387-8810 or 387/5442 any time.

NOVEMBER 1978
Volume 74, Number 11

THE OHIO STATE Medical Journal



CONTINUING EDUCATION EXAMINATION ARTICLE

"ESTROGEN THERAPY"

LIBRARY
U.C. SAN FRANCISCO
NOV 30 1978

THE LIBRARY
ACQUISITIONS DIVISION
UNIVERSITY OF CALIFORNIA, SAN FRAN.
SAN FRANCISCO, CALIFORNIA 94143

STA

PERFORMANCE. PROVEN EFFECTIVENESS WITHIN A WIDE SAFETY MARGIN.



While Roche Laboratories already knows more about the performance of Librium than anyone else, we keep on learning every day.

For example, the highly favorable benefits-to-risk ratio of Librium is a well-documented matter of record.

And, of course, the specific calming action of Librium has been demonstrated in millions of patients around the world. In a large number of these patients, Librium was used concomitantly with other primary medications.

Proven performance within a wide safety margin. Basically, that's what Librium is all about.

LIBRIUM® Ⓒ℞

chlordiazepoxide HCl/Roche

THE ANXIETY-SPECIFIC

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

ROCHE

Roche Products Inc.
Manati, Puerto Rico 00701

Legislative Update

the state scene

(Courtesy the OSMA Department of State Legislation)

Optometric Drug Bill Coming Up for Vote in Judiciary Committee

Rep. Harry Lehman (D-Cleveland), Chairman of the House Judiciary Committee, has announced that when the General Assembly reconvenes in November, he will call for a vote in the Committee on SB 163 (Jackson, D-Cleveland), the optometric drug bill.

Rep. Lehman met with representatives of the OSMA, Ohio Ophthalmological Society, and Ohio Optometric Association to discuss his intentions regarding SB 163. He indicated that he will have a substitute bill drafted and presented to the Committee during the second week of November. If the bill is defeated again as it was in April, the issue is dead for this year.

Although Mr. Lehman has attempted to resolve the differences between the physicians and the optometrists, the OSMA continues to oppose the bill that would legislate optometric (nonmedical practitioner) use of dangerous drugs without adequate training for the purpose of diagnosis.

The Optometric Association and its members have pushed SB 163 for almost four years, and they have come too far to lose the initiative now. Every optometrist in the State of Ohio will be pushing for passage of SB 163 during the November session, no matter what amendments are inserted into the bill.

The only way the OSMA can stop this legislation is for all physicians— regardless of specialty— to discuss the problems associated with SB 163 with their local representatives and members of the House Judiciary Committee. The legislators need to understand the complexities of medical diagnosis and the induction of drugs into the body. If physicians fail to communicate these concerns effectively to the legislators, SB 163 will pass.

The members of the House Judiciary Committee are:

Harry J. Lehman, Chairman, Cleveland (D)
1100 Citizens Building, 44111.

Paul R. Leonard, Vice Chairman, Dayton (D)
2815 Lake Shore Place, Apt. #402, 45420.

William G. Batchelder, Medina (R)
124 W. Washington St., Box 394, 44256.

James E. Betts, Rocky River (R)
1331 Orchard Park Dr., 44116.

Arthur V. N. Brooks, Cleveland Heights (D)
2385 Kenilworth Road, 44106.

Dennis E. Eckart, Euclid (D)
31 Luikart Drive, 44123.

Edward F. Feighan, Cleveland (D)
2805 Clinton Avenue, 44113.

Richard D. Finan, Cincinnati (R)
3068 Stanwin Place, 45241.

Michael A. Fox, Hamilton (R)
606 Haldimand Ave., 45013.

William J. Healy, Canton (D)
1915 Morris Avenue, N.E., 44705.

William L. Mallory, Cincinnati (D)
907 Dayton Street, 45214.

Edward J. Orlett, Dayton (D)
721 Salem Avenue, 45406.

Michael G. Oxley, Findlay (R)
301 East Main Cross Street, 45840.

Donna Pope, Parma (R)
3915 Longwood Avenue, 44134.

Thomas A. Pottenger, Cincinnati (R)
2085 Danville Drive, 45238.

Kenneth A. Rocco, Cleveland (D)
1640 Illuminating Building, 44113.

Charles Rockwell Saxbe, Mechanicsburg (R)
177 East Sandusky St., 43044.

Cliff Skeen, Akron (D)
3255 Carper Avenue, 44312.

Mike Stinziano, Columbus (D)
2147 West Broad Street, 43203.

Terry M. Tranter, Cincinnati (D)
1900 Kroger Building, 45202.

Certificate-of-Need Bill to Be Reported to Finance Committee

The House Finance Subcommittee, which is reviewing SB 349 (Valiquette, D-Toledo)—the Certificate-of-Need Bill—, intends to report the legislation to the full Finance Committee for consideration during the postelection November session. The proponents of SB 349 hope to secure passage by the Finance Committee and the full House and concurrence by the Senate during the three-week session.

The OSMA opposes several provisions of SB 349, which extends the certificate-of-need law beyond the federal requirements established under the National Health Resources and Development Act of 1974 (PL 93-641). The Ohio Department of Health complied with the federal mandate for certificate-of-need review by promulgating regulations last spring. However, some members of the General Assembly continue to promote SB 349.

The significance of the certificate-of-need (CON) and mandatory health planning proposals is not understood by most legislators. To date, a majority of their

(continued on next page)

Legislative Update *(continued)*

physician-constituents have not argued effectively the problems of extending certificate-of-need review to physician offices. Even the United States Congress refused to pass a bill extending CON coverage during the recently ended session. The original federal law was intended to control major capital expenditures by health care facilities, not physician offices. Arguments that CON is ideally designed to help control increasing medical costs have not been proved.

Physicians need to contact members of the House Finance Committee and their local representatives immediately to inform them of the problems in SB 349. In addition, they need to discuss the fact that SB 349 is unnecessary due to the rules promulgated by the Ohio Department of Health.

Regardless of specialty, all physicians should be vitally concerned with this bill. Although some physicians may not purchase equipment costing in excess of $100,000, there is no guarantee that this proposed limit will not be revised. Already, it is $50,000 less than the federal mandate for hospital certificate-of-need reviews.

By using personal example, the following basic arguments show the potential problems in SB 349:

(1) Federal regulations implementing PL 93-641 specifically exclude physicians' offices from the certificate-of-need requirements; and therefore, it is not necessary to include physicians' offices under state CON laws in order to be in compliance with the federal law.

(2) The inclusion of physicians' office equipment purchases under certificate of need would discourage physicians from acquiring innovative diagnostic and therapeutic equipment that could improve the quality of medical care. Thus, the level of care that patients could receive would be frozen.

(3) An extension of certificate of need to physician-owned equipment would eliminate competition between hospitals and the offices of private physicians or other outpatient facilities that can deliver health care at substantially lower costs than hospitals.

(4) Certificate of need was conceived in order to control major capital expenditures of institutions which are reimbursed by government and third-party payors on the basis of their costs. However, physicians in private offices are not reimbursed by cost formulae. Their reimbursements are controlled by fee restraints and by review mechanisms which are developing under Medicaid, Medicare, Blue Shield, physician service review organizations, and foundations.

OSMA members are urged to contact members of the House Finance Committee to express your views on SB 349. Members of the Committee are:

Myrl H. Shoemaker, Chairman, Bourneville (D)
Bourneville, 45617.

William E. Hinig, Vice Chairman, New Philadelphia (D)
150 South Broadway, 44663.

Claire M. Ball, Jr., Athens (R)
19 West Washington Street, 45701.

Larry H. Christman, Englewood (D)
7112 Kinsey Road, 45322.

Pete Crossland, Akron (D)
29 Borton Avenue, 44302.

Frederick H. Deering, Monroeville (D)
9601 Ransom Road, 44847.

Scribner L. Fauver, Elyria (R)
252 Hamilton Avenue, 44035.

Thomas P. Gilmartin, Youngstown (D)
825 S. Hazelwood Ave., 44509.

Robert W. Jaskulski, Garfield Heights (D)
10109 Park Hts. Blvd., 44125.

John E. Johnson, Orrville (D)
687 Wadsworth Road, 44667.

Thomas W. Johnson, Cambridge (R)
R.R. #6, 43725.

Casey C. Jones, Toledo (D)
1467 Avondale, 43607.

Rex F. Kieffer, Jr., Zanesville (R)
2201 Dresden Road, 43701.

Richard F. Maier, Massillon (R)
2200 Wales Road, N.W., 44646.

Robert A. Nader, Warren (D)
280 North Park Avenue, 44483.

C. William O'Neill, Columbus (R)
3701 Kennybrook Lane, 43220.

Francine M. Panehal, Cleveland (D)
11502 Edgewater Drive, 44102.

Mack Pemberton, Columbus (R)
2949 Crescent Drive, 43204.

Waldo Bennett Rose, Lima (R)
330 South Charles Street, 45801.

Mike Stinziano, Columbus (D)
2147 West Broad Street, 43203.

Patrick A. Sweeney, Cleveland (D)
3545 West 100th Street, 44111.

George D. Tablack, Campbell (D)
756 Porter Avenue, 44405.

Robert A. Taft II, Cincinnati (R)
712 Glenshire Avenue, 45226.

John P. Wargo, Lisbon (D)
344 East Chestnut Street, 44432.

House Seats Two New Members

The Ohio House of Representatives has seated two new members. Helen Rankin, a Cincinnati Democrat, was elected to succeed her late husband, James W. Rankin, in the 25th House District. Mr. Rankin died of pneumonia in June. Mrs. Rankin is the first Black woman to serve in the Ohio House.

Dale Van Vyven, a Cincinnati Republican, was elected to succeed Richard Finan, also of Cincinnati, in the 19th House District. Mr. Finan resigned September 14 to accept appointment to the 7th Senate District. The seat was left vacant by the resignation of Michael Maloney, who accepted an appointment as Hamilton County administrator. ☆☆☆

OSMA OFFICERS

President
JOHN J. GAUGHAN, M.D.
7911 Detroit Avenue
Cleveland 44102

President-Elect
THOMAS W. MORGAN, M.D.
P.O. Box 344
Gallipolis 45631

Past President
WILLIAM M. WELLS, M.D.
241 Hudson Avenue
Newark 43055

Secretary-Treasurer
ROBERT G. THOMAS, M.D.
630 East River Street
Elyria 44035

EDITORIAL STAFF

Consulting Medical Editor
Richard L. Meiling, M.D.

Managing Editor and Business Mgr.
Hart F. Page

Executive Editor and Executive Business Manager
Linda A. Porterfield

Editorial Assistant
Mary Lou Brady

Communications Editor
Rebecca J. Doll

Continuing Medical Education Editors
Gail E. Dodson
David C. Torrens

Federal Legislation Editor
Charles W. Edgar

Field Service Editor
Robert E. Holcomb

Government Relations Editor
Herbert E. Gillen

Health Education Editor
Robert D. Clinger

Membership Editor
Katherine E. Wisse

Organization Services Editor
Jerry J. Campbell

State Legislation Editors
D. Brent Mulgrew, J.D.
Richard A. Ayish

Address All Correspondence, Address Change, & Reprint Request (unless otherwise noted): Executive Editor, The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215. Phone: 614/228-6971.

Published monthly under the direction of The Council for and by members of The Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215, a scientific society, nonprofit organization, with a definite membership for scientific and educational purposes.

1979 Subscription: $15 per year, single copy $2 (outside U.S. $20 and $3).

Entered as second class matter July 5, 1905, at the Post Office at Athens, Ohio, under the Act of Congress of March 3, 1879. Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918. Second-Class Postage Paid at Athens, Ohio.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertisers must conform to policies and regulations established by The Council of the Ohio State Medical Association.

Publication office: 900 East State Street, Athens, Ohio 45701.

Printed by
The Lawhead Press, Inc., Athens, Ohio

VOL. 74 NOVEMBER 1978 NO. 11

THE OHIO STATE Medical Journal

Clinical and Scientific Articles

ESTROGEN THERAPY 691
Moon H. Kim, M.D., Columbus; Claude S. Hambrick, M.D., Dayton; William J. Keating, M.D., Fairview Park; William H. Kose, M.D., Findlay; and Edwin H. Season, M.D., Columbus

CONTINUING EDUCATION EXAMINATION 707

PHYSICAL TREATMENT OF PAIN AND WEAKNESS FOLLOWING RADICAL NECK DISSECTION 711
Ernest W. Johnson, M.D., Columbus; John N. Aseff, M.D., Cincinnati; and William Saunders, M.D., Columbus

MELANOMA AND ITS IMMUNOTHERAPY 717
Jeanne A. Petrek, M.D., New York City; and John P. Minton, M.D., Columbus

DISEASES DESCRIBED BY OHIOANS 723
George W. Paulson, M.D., Columbus

Special Articles

REPORT ON THE OSMA DISTRICT MEETINGS 727

Features

Legislative Update — State....669
Manuscript Guidelines 672
Obituaries 676
Letters to the Editor.....679
Continuing Education Programs...683
Proceedings of the Council.....685
News 689
Classified Ads 733
Journal Advertisers 734

COVER: Entitled "Sunset Over the Ding Darling Bird Sanctuary on Sanibel Island, Florida," this photograph was taken by Henry Bachman, M.D., McConnelsville. Dr. Bachman entered the photograph in the 1978 *Journal* Photographic Exhibit and received an Outstanding Entry Award. In taking the picture, he used a Leica CL camera and Kodachrome ASA 25 film. (Lens— 40 mm Summicron C, F-2; Aperture— 5.6; Speed— 1/30.) The scene was captured on October 30, 1977 at 6 PM. **For information regarding the next *Ohio State Medical Journal* Photographic Exhibit, see page 680 of this issue.**

Copyright 1978. The Ohio State Medical Association. All material subject to this copyright may be photocopied for the noncommercial purpose of scientific or educational advancement.

Ohio State Medical Journal Manuscript Guidelines

1. **EXCLUSIVE PUBLICATION.** Articles are accepted for publication with the understanding that they are contributed solely to this *Journal*. Permission for subsequent publication elsewhere must be obtained in writing from the Editor and from the Author.

2. **CORRESPONDENCE.** Address all correspondence relating to publication of scientific papers to: The Consulting Medical Editor, The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

3. **MANUSCRIPTS.** (a). Manuscripts should be submitted *in the original* on standard 22 × 28-cm (8½ × 11-inch) white typing paper.

(b). A copy of the manuscript should be retained by the Author.

(c). *The entire text including lists of REFERENCES should be TYPED DOUBLE OR TRIPLE SPACED with margins of at least one inch on all sides.*

(d). Tables, charts, and figures (illustrations) should be submitted separately from the text. They should be identified by number and by concise, descriptive titles. In the text, reference to them should be by number, eg, (Fig. 1).

4. **ILLUSTRATIONS.** (a). Illustrations (photographs, drawings, graphs, and tables) will be submitted to the printer for an estimate of cost. *The Journal* will assume $10 of this expense and the author will be billed by *The Journal* for the remainder.

(h). Each illustration should bear the figure numher and the author's name on the back. When pertinent, the top of the photograph should be indicated. Do not clip, write on the back with a hard pencil, or otherwise mutilate the prints.

(c). Legends for the figures should be written on separate paper.

(d). The author must affirm that he has *written releases* on all photographs in which patients can be identified.

5. **ABSTRACTS.** *A short* (100-word maximum) abstract should be included with the article. It should cover the main points so that the reader may readily obtain the gist of the article.

6. **SUMMARIES.** The summary should be a concise restatement of the information given in the body of the article.

7. **REFERENCES.** (a). Lists of references should be at a minimum to conserve space and expense and be limited to those essential to the subject and to which actual reference is made in the text. The Editor reserves the right to reduce the numher when necessary.

(b). References should he listed in the *order of their appearance in the text.*

(c). Authenticity and accuracy are the responsihilities of the Author.

(d). Each journal reference should include in this order: Author's last name and initials, title of article, name of journal (abbreviated in accordance with standard usage), volume number, inclusive page numbers, and year.

"2. Doe J, Roe RX: How to go ahout it. Ohio State M J 13:24-30, 1920"

Each texthook reference should include, in this order: Author's surname and initials, title of the book (capitalize all main words), edition, place of publication, name of the publisher, year of publication, volume, if more than one has been published, and page.

"5. Osler W: Modern Medicine, ed 3, Philadelphia, Lea & Fehiger, 1927, vol 5, p 66."

8. **IDENTIFICATION OF PATIENTS.** Names, initials, hospital numbers, or any other identifiable labels, should *not* be used. It is preferable to identify patients for the purpose of publication by the use of numbers in series for the study being reported.

9. **METRICATION.** All measurements must he in metric units. English units should be given in parentheses following the metric in all cases where the measurement was originally done in English units.

10. **EDITING OF MANUSCRIPT.** Following acceptance of a manuscript for puhlication, it will be copy edited in conformance with the editorial standards of the American Medical Association, which *The Journal* follows. The copy-edited manuscript will be returned to the Senior Author for approval. At that time, he is asked to make all corrections and to have the manuscript retyped. Any changes, other than typographical errors, made by the Author after the manuscript is set in type will be billed to him at $1 per line.

11. **REPRINTS.** An order blank for reprints with a table covering cost will be sent with the galley proofs to the Senior Author. *The Journal* does not profit on reprint orders.

12. **EDITORIAL ASSISTANCE.** Miss Mary Lou Brady, *Journal* Editorial Assistant, stands ready to assist the Author in preparing his manuscript. For his own assistance, however, the Author is encouraged to consult standard texts on medical writing, such as the *Style Book and Editorial Manual,* prepared by the Scientific Puhlications Division, American Medical Association, 535 North Dearhorn Street, Chicago, Illinois 60610.

Librax®

Each capsule contains 5 mg
chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

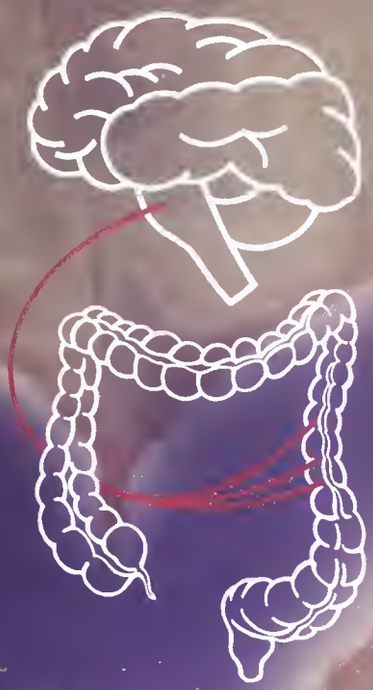
As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

ROCHE

Roche Products Inc.
Manati, Puerto Rico 00701



In treating irritable bowel syndrome*

Enhance your therapeutic expectations with

Librax®

Each capsule contains
5 mg chlordiazepoxide HCl
and 2.5 mg clidinium Br.

antianxiety/antispasmodic/antimotility

Librax is unique among G.I. medications in providing the specific antianxiety action of LIBRIUM®(chlordiazepoxide HCl) as well as the potent antispasmodic and antimotility actions of QUARZAN®(clidinium Br) for adjunctive therapy of irritable bowel syndrome.

ROCHE

*Librax has been evaluated as possibly effective for this indication.
Please see brief summary of prescribing information on preceding page.

ANCEF®

brand of sterile

CEFAZOLIN SODIUM

GETS TO THE SITE



OF SERIOUS RESPIRATORY INFECTIONS

'Ancef' Penetrates Pleural Fluid

"...levels of cefazolin in pleural fluid...generally exceeded the median MICs of all organisms commonly associated with respiratory tract infections, with the exception of a small number of isolates of Klebsiella and H. influenzae.

—Cole, D.R., et al.: Antimicrob. Ag. Chemother. 11(6):1033-1035 (June) 1977.

Tissue penetration is essential to therapeutic efficacy; however, specific tissue levels have not been directly correlated with specific therapeutic results.

Before prescribing, see complete prescribing information in SK&F literature or PDR. The following is a brief summary.

Indications: Ancef® (sterile cefazalin sadium, SK&F) is indicated in the treatment of the following seriaus infections due to susceptible organisms:

Respiratary tract infectians due to Streptococcus pneumoniae (formerly D. pneumoniae), Klebsiella species, Hemophilus influenzae, Staphylocaccus aureus (penicillin-sensitive and penicillin-resistant), and graup A beta-hemolytic streptacocci.

Injectable benzathine penicillin is considered to be the drug of choice in treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. 'Ancef' is effective in the eradication of streptococci from the nasopharynx; however, data establishing the efficacy of 'Ancef' in the subsequent prevention of rheumatic fever are not available at present.

Urinary tract infections due to Escherichia coli, Proteus mirabilis, Klebsiella species, and some strains af enterobacter and enterococci.

Skin structure infectians due to Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), group A beta-hemolytic streptacacci and other strains of streptacacci.

Biliary tract infectians due to Escherichia coli, various strains of streptococci, Proteus mirabilis, Klebsiella species and Staphylacaccus aureus.

Bane and jaint infectians due ta Staphylococcus aureus.

Genital infectians (i.e., prostatitis, epididymitis) due to Escherichia coli, Proteus mirabilis, Klebsiella species, and some strains of enterococci.

Septicemia due to Streptacoccus pneumoniae (farmerly D. pneumaniae), Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), Prateus mirabilis, Escherichia coli, and Klebsiella species.

Endacarditis due ta Staphylococcus aureus (penicillin-sensitive and penicillin-resistant) and group A beta-hemalytic streptacacci.

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to 'Ancef'.

Contraindications: ANCEF (STERILE CEFAZOLIN SODIUM, SK&F) IS CONTRAINDICATED IN PATIENTS WITH KNOWN ALLERGY TO THE CEPHALOSPORIN GROUP OF ANTIBIOTICS.

Warnings: BEFORE CEFAZOLIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY IN PENICILLIN-SENSITIVE PATIENTS.

SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence af partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reparted to have had severe reactians (including anaphylaxis) to both drugs.

Any patient wha has demonstrated some form of allergy, particularly to drugs, should receive antibiatics cautiausly. No exceptian shauld be made with regard ta 'Ancef'.

Usage in Pregnancy: Safety of this product for use during pregnancy has not been established.

Usage in Infants: Safety for use in prematures and infants under 1 month of age has not been established.

Precautions: Prolonged use of 'Ancef' may result in the overgrowth of nonsusceptible organisms. Careful clinical observation af the patient is essential.

When 'Ancef' is administered to patients with low urinary output because of impaired renal function, lower daily dosage is required (see dosage instructions). A false positive reaction for glucose in the urine of patients on 'Ancef' has accurred with Clinitest® tablets solution.

Adverse Reactions: The following reactians have been reported: Hypersensitivity: Drug fever, skin rash, vulvar pruritus, and eosinaphilia have accurred. Blaad: Neutrapenia, leukapenia, thrambocythemia and pasitive direct and indirect Coombs tests have accurred. Hepatic and Renal: Transient rise in SGOT, SGPT, BUN and alkaline phosphatase levels has been observed withaut clinical evidence of renal or hepatic impairment. Gastraintestinal: Nausea, anorexia, vomiting, diarrhea, oral candidiasis (aral thrush) have been reported. Other: Pain at site of injection after intramuscular administratian has occurred, some with induratian. Phlebitis at site of injection has been nated. Other reactions have included,genital and anal pruritus, genital maniliasis, and vaginitis.

How Supplied: Ancef® (sterile cefazolin sadium, SK&F)—supplied in vials equivalent ta 250 mg., 500 mg., or 1 gram of cefazolin; in "Piggyback" Vials far intravenaus admixture equivalent to 500 mg. or 1 gram af cefazalin; and in Pharmacy Bulk Vials equivalent to 5 grams or 10 grams of cefazalin.

ANCEF® IV IM

brand of sterile

CEFAZOLIN SODIUM

(LYOPHILIZED)

Injection: 250 mg., 500 mg. and 1 gram vials

Smith Kline &French Laboratories
Philadelphia, Pa.

SK&F
a SmithKline company

THE OHIO STATE Medical Association Obituaries



George H. Saville

GEORGE H. ("SCOTTIE") SAVILLE, former executive secretary of the Ohio State Medical Association, died October 12, 1978 in Columbus. A member of the staff of the OSMA since 1935, Mr. Saville served successively as assistant executive secretary, director of public relations, and executive secretary. He also was news editor, managing editor, and business manager of *The Ohio State Medical Journal.* He retired from the Association in 1964.

Born August 13, 1900 in Kirkcaldy, Scotland, Mr. Saville immigrated to the United States with his parents in 1912, settling in Conneaut, Ohio. Following graduation from Ohio Wesleyan University, Delaware, Mr. Saville entered the window glass business; and after 12 years in sales and promotion of that product, he joined the staff of the OSMA.

Mr. Saville served as president of the Ohio Trade Association Executives, Central Ohio Chapter of the Public Relations Society of America, and Ohio Wesleyan University Alumni Association. He received numerous honors including ones from the American Medical Association, Ohio Public Health Association, and the OSMA.

Mr. Saville is survived by his wife of 55 years, Margaret, three children, and seven grandchildren.

LOUIS BERMAN, M.D., Zanesville; Medizinische Fakultat der Universitat Bern, Bern, Switzerland, 1935; age 73; died August 26; member OSMA and AMA.

BRUCE HARROLD, M.D., Dalton; Jefferson Medical College of Philadelphia, 1948; age 58; died August 14; member OSMA and AMA.

DANIEL J. KINDEL III, M.D., Cincinnati; The Ohio State University College of Medicine, 1961; age 50; died August 20; member OSMA and AMA.

NICHOLAS J. LIBEN, M.D., Cleveland; Faculty of Medicine, National University of Athens, Athens, Greece, 1954; age 50; died August 3; member OSMA and AMA.

NEVIN CALVIN MAYER, M.D., Apple Creek; Western Reserve University School of Medicine, Cleveland, 1917; age 88; died August 13; member OSMA and AMA.

MERRETT C. McCUSKEY, M.D., Cambridge; Western Reserve University School of Medicine, Cleveland, 1928; age 76; died August 21; member OSMA and AMA.

HARVEY H. MUSSER, M.D., Columbus; Johns Hopkins University School of Medicine, Baltimore, 1915; age 89; died September 24; member OSMA and AMA.

MIROSLAUS ORLOWSKY, M.D., Brunswick; Uniwersytet Jana Kazimierza Wydzial Lekarski, Lwow, Poland, 1943; age 62; died August 31; member OSMA and AMA.

HOWARD J. PARKHURST, M.D., Green Bay, Wisconsin; Western Reserve University School of Medicine, Cleveland, 1918; age 85; died June 20, 1976; member OSMA and AMA.

RUSSELL M. PIERSON, M.D., Houston, Texas; Eclectic Medical College, Cincinnati, 1920; age 84; died September 5; member OSMA and AMA.

JOSEPH A. QUIGLEY, M.D., El Paso, Texas; Queen's University Faculty of Medicine, Kingston, Ontario, 1937; age 68; died September 5; member OSMA and AMA.

BERNARD M. SCHNEIDER, M.D., Hubbard; The Ohio State University College of Medicine, 1940; age 63; died August 13; member OSMA and AMA.

NATHAN SILVER, M.D., Cincinnati; University of Cincinnati College of Medicine, 1939; age 66; died August 22; member OSMA and AMA.

WILLIAM F. SOHNGEN, M.D., Cincinnati; University of Cincinnati College of Medicine, 1931; age 76; died July 29; member OSMA and AMA.

JAMES C. SPENCE, M.D., Milford; Eclectic Medical College, Cincinnati, 1928; age 85; died September.

KEITH R. WOODROFFE, M.D., Columbus, Faculte de Medecine de l'Universite de Lausanne, Lausanna, Switzerland, 1962; age 47; died September 2; member OSMA.

The Ohio State University
Center for Continuing Medical Education

announces

RECENT ADVANCES IN CLINICAL THERAPEUTICS-1978

Saturday and Sunday, December 2-3, 1978
Fawcett Center for Tomorrow
2400 Olentangy River Road
Columbus, Ohio

SPONSORED BY: The Ohio State University College of Medicine Center for Continuing Medical Education, and Departments of Pharmacology, Family Practice, and Medicine

OBJECTIVES: Keeping abreast of important advances in the drug treatment of disease is an important and formidable task for all practitioners of medicine. The major aim of this symposium is to present important facts about selected new drugs and to suggest how these drugs can be used rationally in clinical practice. Crisp, short, formal presentations and opportunities to meet with faculty in small, informal sessions will be available.

VISITING FACULTY:

★ **R. Robert Fekety, M.D.,** Professor of Internal Medicine; Head, Division of Infectious Disease, University of Michigan, Ann Arbor
★ **Charles Hillenbrand, M.D.,** Clinical Instructor, Department of Psychiatry, Loyola University, Chicago
★ **James R. Klinenberg, M.D.,** Director, Department of Medicine, Professor of Medicine, Cedars-Sinai Medical Center, U.C.L.A., Los Angeles
★ **Carlos Lamar, M.D., Ph.D.,** Chief of Medicine, Veterans Administration Hospital; Professor of Medicine, University of South Carolina, Charleston
★ **James K. Luce, M.D.,** Director of Medical Services, Adria Corporation, Columbus, Ohio
★ **John Lukens, M.D.,** Associate Professor, Department of Psychiatry, Michigan State University, Flint
★ **Simeon Margolis, M.D., Ph.D.,** Professor of Medicine; Director, Division of Endocrinology, The Johns Hopkins University, Baltimore, Maryland
★ **Donald L. Meyer, Ph.D.,** Technical Director, Consolidated Biomedical Laboratories, Inc., Columbus, Ohio
★ **Andrew Whelton, M.D.,** Associate Professor of Medicine, Division of Nephrology, The Johns Hopkins University, Baltimore, Maryland
★ **Frederick Wolff, M.D.,** Professor of Medicine, The George Washington University, Washington, D.C.
★ **Avraham Yacobi, Ph.D.,** Associate Professor, Department of Clinical Pharmacology and Drug Metabolism, Arnar Stone Laboratories, Mt. Prospect, Illinois

THE OHIO STATE UNIVERSITY FACULTY:

★ **Joseph R. Bianchine, Ph.D., M.D.,** Professor and Chairman, Department of Pharmacology; Professor, Department of Medicine
★ **Lauren M. Brown, M.D.,** Clinical Associate Professor, Department of Family Medicine
★ **Moon H. Kim, M.D.,** Associate Professor, Department of Obstetrics and Gynecology
★ **Thomas M. O'Dorisio, M.D.,** Associate Professor, Department of Medicine, Division of Endocrinology
★ **George W. Paulson, M.D.,** Professor, Department of Medicine, Division of Neurology
★ **Douglas A. Rund, M.D.,** Assistant Professor and Director, Division of Emergency Medicine
★ **Helmut S. Schmidt, M.D.,** Associate Professor, Department of Psychiatry
★ **John M. Stang, M.D.,** Assistant Professor, Department of Medicine, Division of Cardiology
★ **Fred B. Thomas, M.D.,** Associate Professor, Department of Medicine, Division of Gastroenterology
★ **Paul Weber, M.D.,** Clinical Instructor, Department of Ophthalmology
★ **Ronald L. Whisler, M.D.,** Assistant Professor, Department of Medicine, Division of Rheumatology
★ **Tennyson Williams, M.D.,** Professor and Chairman, Department of Family Medicine
★ **Elizabeth A. Young, M.D.,** Clinical Instructor, Department of Psychiatry

CREDIT: As an organization accredited for continuing medical education, The Ohio State University College of Medicine Center for Continuing Medical Education certifies that this continuing medical education offering meets the criteria for 12 hours in Category I of the Physician's Recognition Award of the American Medical Association and the Ohio State Medical Association provided it is used and completed as designed.
Program is accepted for 12 prescribed hours by the American Academy of Family Physicians.

REGISTRATION: The registration fee of $75 includes lunches, coffee, and all educational materials. Send registration fee on your letterhead, to:

Center for Continuing Medical Education, A352 Starling Loving Hall, 320 West Tenth Avenue, Columbus, Ohio 43210, phone: 614/422-4985.

OHIO STATE MEDICAL ASSOCIATION

Egypt/Greek Isles Adventure



A Two Week Luxury Holiday to The Land of the Pharaohs and Cruising the Seas of Ulysses Via Chartered World Airways Jet

Departing Columbus on April 13, 1979

Egypt and The Greek Isles . . . two of the world's most sought after and rewarding travel destinations now for the first time have been combined into one great, deluxe trip.

Visit the Sphinx and the Pyramids. See the Temple of Karnak at Luxor. Relax on a luxury cruise among the white-washed villages of Santorini, Hydra, Rhodes and Mykonos.
Don't miss the most exciting trip of this or any other year.
From only $1698

Send to: Ohio State Medical Association
600 South High Street
Columbus, Ohio 43215

Enclosed is my check for $_____ ($200 per person) as deposit.

Names _____

Address _____

City _____ State _____ Zip _____

Area Code _____ Phone _____

Space Strictly Limited—Make Reservations Now

A Non-Regimented INTRAV® Deluxe Adventure

THE OHIO STATE Medical Association

Letters to the Editor

To the Editor:

I very much enjoyed the article by Arthur G. James, M.D., on surgery of breast cancer in the August issue of *The Journal.*

I believe that reprints of this article given to patients who face this problem would greatly facilitate my explanations of the "whys" and "wherefores" of the choices.

I would like to purchase 200 reprints of the article. I would be pleased if you would send them as soon as practical.

/s/Harold J. Bowman, M.D.
Canton, Ohio 44703

* * *

To the Editor:

It is very unfortunate that Dr. Arthur G. James misled by quoting an unqualified reference on lumpectomy plus radiation therapy in his recent article in The OSMJ Cancer Education Series.[1] If he knows, as he stated in the article, that people turn on television to a talk show and hear a doctor state, that breast cancer should be treated by radiation therapy, he should not use this particular reference,[2] because that is not what you talk about these days. That particular article reviewed past treatment from three institutions and compared to radical mastectomy, which seems to be comparing an orange to an apple. May I bring his attention to the recent report, [3,4] which show impressive five-year survivals comparable to that by radical mastectomy.

/s/ Y. Joe Kwon, M.D.
Dayton, Ohio

References

1. James AG: How much surgery for cancer of the breast. *Ohio State Med J* **74**:498-499, 1978.
2. Farrow JH, et al: Simple excision or biopsy plus radiation therapy as the primary treatment for potentially curable cancer of the breast. *Cancer* **28**:1195, 1971.
3. Levene MB, et al: Treatment of carcinoma of the breast by radiation therapy. *Cancer* **39**:2840, 1977.
4. Pierquin B, et al: The radical radiotherapy of breast cancer: A study of 400 cases treated at Hospital Henri Mondor, in *International Journal of Radiation Oncology, Biology & Physics,* vol 2, supp 1, 43, 1977.

To the Editor:

In the article I referred to in my August 1978 Ohio State Medical Association *Journal* paper, the results for lumpectomy plus radiation therapy were quoted by the author as being a 31% five-year crude survival rate; these dropped to 2.6% by 10 years.

In the article by Levene et al, cited by Dr. Kwon, the paper referred to "survival probability." The material was obtained during the period from July 1, 1968 to December 31, 1974, and the article was accepted for publication in January 1977. Five-year follow-up studies on all the patients would not be completed until December 31, 1979.

The article by B. Pierquin et al, that Dr. Kwon refers to, reports only five-year results.

In both studies, referred to by Dr. Kwon, longer follow-up periods would be desirable.

/s/ Arthur S. James, M.D.
Columbus, Ohio

* * *

To the Editor:

I do not intend to argue with Dr. Arthur James about how breast cancer should be treated, but I would like to ask him to either withdraw the statement that he made about me or give the reference to the article on which he alleges that his statement is based.

In Doctor James' article, "How Much Surgery for Breast Cancer?," OSMA, August 1978, the sentence that I object to is, "She reads an article by Dr. George Crile, Jr. that a lumpectomy is all that is necessary for cure."

I have never advocated lumpectomy. I have advocated partial mastectomy only in highly selected cases. I have never implied that any operation done for breast cancer guarantees a cure.

/s/ George Crile, Jr., M.D.
Cleveland, Ohio

To the Editor:

In trying to explain why women are confused when they discover a breast lump, I was referring to the literature that lay people read in this regard.*

In fairness to Dr. Crile, I know of no article he has published advocating "lumpectomy." He has published articles in the medical literature on treatment of breast

(continued on next page)

Letters *(continued)*

cancer by partial mastectomy, by limited mastectomy and by local excision. In my article in the OSMA *Journal,* I used the terms local excision and lumpectomy interchangeably. I believe this is a matter of definition, and if, in Dr. Crile's opinion, I have misstated, he has my apology.

/s/ Arthur G. James, M.D.
Columbus, Ohio

---

*1. *Vogue Magazine,* February 1973.
2. *McCall's Magazine,* April 1971.
3. *The Columbus Dispatch,* October 15, 1970, page 17-A.
4. *The Toledo Times,* December 13, 1972, page 6.

* * *

To the Editor:

I am interested in obtaining four extra copies of your June 1978 issue (Volume 74, No. 6) for use in our residency practice management course.

Please let me know if these would be available and what the cost would be. Thank you.

/s/Joseph E. Chase, M.D.
Akron, Ohio 44310

To the Editor:

Please send me details on our exhibiting *The Journal* Photographic Exhibit (1979). My husband is an M.D. and I admired your Waylonis cover.*

/s/Anne Baker
Director
Lima Art Association

---

*Vol. 74, No. 8, August 1978.

Attention OSMA Members and Spouses:

Due to the interest in the 1978 *Journal* Photographic Exhibit, *The Ohio State Medical Journal* again will sponsor its exhibit in 1979. Held in conjunction with the 1979 OSMA Annual Meeting, the second Photographic Exhibit will offer categories for color and black-and-white pictures. However, unlike the first exhibit, both *physicians and their spouses are eligible* to enter the 1979 Photographic Exhibit.

If you enjoy this month's *Journal* cover (and those of July, August, and October) and would like to show your photographic skills to the OSMA membership, consider being a part of the 1979 exhibit. Complete details and an entry form will appear in the December issue of *The Journal.*

IMMKE CIRCLE LEASING INC

Endorsed Leasing Company
Of The Ohio State Medical Association

Order now for early delivery on all 1979 models

We lease all foreign and domestic makes and models
including Mercedes, Jaguar, Porsche, etc.

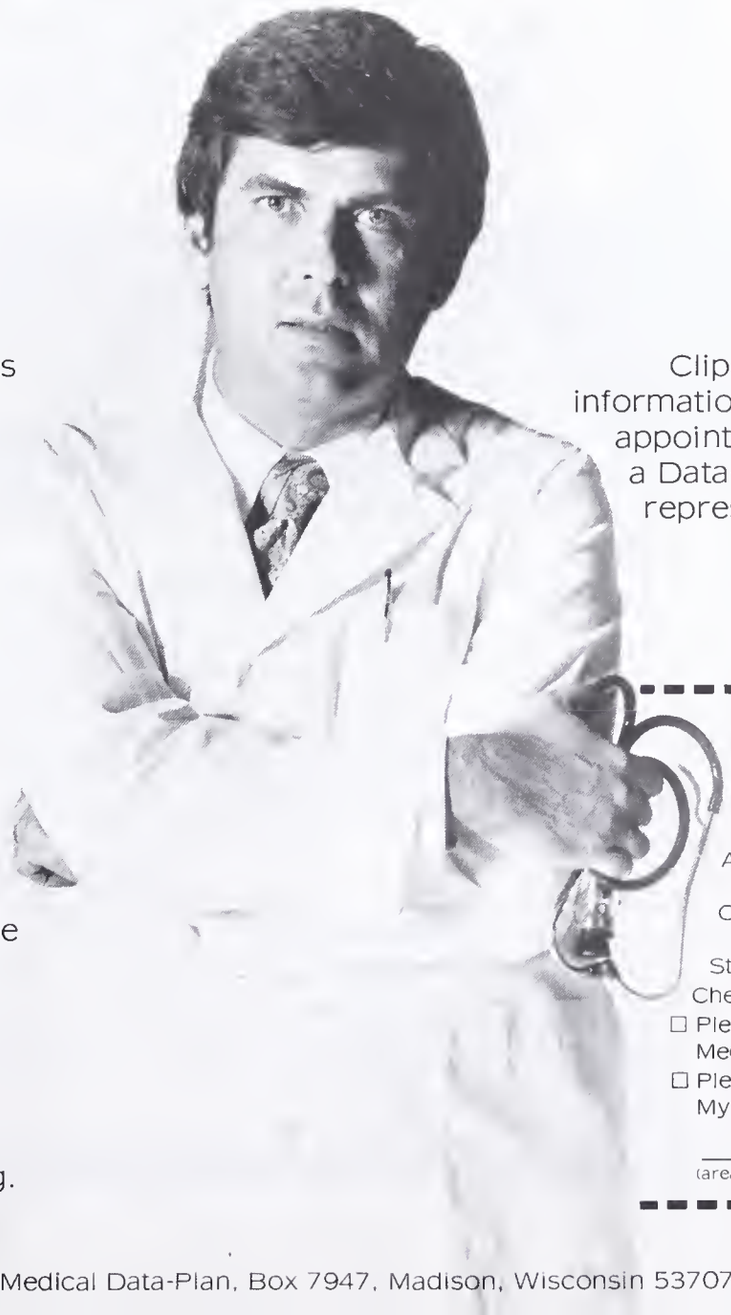
Many people think of leasing as just automobiles.
We do that too, but, in addition, we want to lease you any professional equipment.

Immke Circle Leasing, Inc.
32 South Fifth Street
Columbus, Ohio 43215

Telephone 614-228-1701 or Toll Free 1-800-282-0256

Medical Data-Plan®

We're not offering you just a computerized billing system. We're offering you a way to plan the future of your practice.



Medical Data-Plan is a computerized system for getting bills out, processing insurance forms, speeding up cash flow and improving collections.

It also gives you the information you need to plan the future of your practice . . . 3 years, 5 years, 10 years from now.

Based on a steady flow of accurate, timely computer reports, your business manager can make sound recommendations on personnel, equipment, materials, facilities and more. Medical Data-Plan can show you what your practice has been doing—and what it should be doing.

Clip this coupon to receive information or to arrange an appointment with a Data-Plan representative.

Data-Plan

Medical Data-Plan OM 811
Box 7947, Madison, Wisconsin 53707

Name _____

Address _____

City _____

State _____ Zip _____

Check one or both boxes below:

☐ Please mail me more information about Medical Data-Plan.

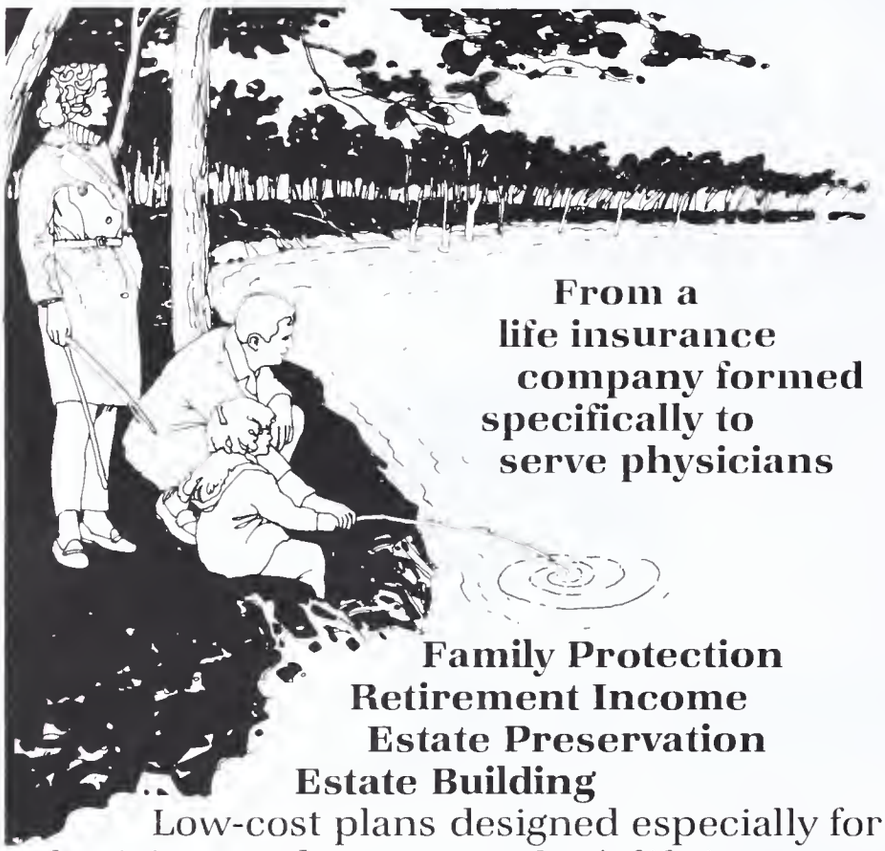
☐ Please have a representative contact me. My phone number is:

_____
(area code) (number)

Medical Data-Plan, Box 7947, Madison, Wisconsin 53707

picolife

Life Insurance, With A Difference



From a life insurance company formed specifically to serve physicians

Family Protection
Retirement Income
Estate Preservation
Estate Building

Low-cost plans designed especially for physicians and surgeons...that's life insurance, with a difference.

A Pico Life sales representative will give you a confidential, no-obligation rate quotation on one or several plans that best fit your own particular situation.

Telephone 614-864-0280 or write to the home office to set up a brief appointment.

picolife

Pico Life Insurance Company
6100 Channingway Boulevard
Columbus, Ohio 43227
Telephone (614) 864-0280

A Subsidiary of Physicians Insurance Company of Ohio (PICO)

The Ohio State Medical Association Continuing Education Programs

Editor's Note: *The following are Category I courses offered in Ohio. Items for this listing come from many sources, often far in advance of the publication date. Sometimes, cancellations or changes in dates, places, or time occur too late to be corrected before publication. Physicians interested in a course are urged to contact the sponsoring organization to confirm the information listed. Sponsoring organizations may list Category I courses by contacting the OSMA Department of Continuing Medical Education or The Journal. Notification 90 days prior to the course would be appreciated. Due to space limitations, announcements may be published only once.* **See previous issues of The Journal for additional courses.**—*L.A.P.*

OSMA MEMBERS

The Ohio State Medical Board requests that you send your "Log of Continuing Medical Education Activities" to the Board *as soon as* you complete the 150 hours of CME required for reregistration of your medical license, January 1, 1980.

November 1978

CURRENT NEUROSURGICAL PROBLEMS: November 29-30; Cleveland Clinic Foundation, Cleveland; 12 credit hours; fee: $125, $62 students and physicians-in-training; contact: Phillip Gard, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

December 1978

RESPIRATORY CARE UPDATED: December 1-2, Cleveland Clinic; 12 credit hours; fee: $100, $50 students and physicians-in-training; contact: Director of Continuing Medical Education, Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland 44106, phone: 216/444-5696.

SYMPOSIUM ON STRESS MANAGEMENT: December 2-3, Ramada Inn, 330 W. First Street, Dayton; sponsor: Wright State University School of Medicine; 12 credit hours; fee: $100, $75 WSU Faculty, no fee WSU medical students and physicians-in-training; contact: Arlene L. Polster, Wright State University, Dept. of PMCE, P.O. Box 927, Dayton 45401, phone: 513/372-7140.

PERSPECTIVES IN OPHTHALMOLOGY: December 7-8, Cleveland Clinic; 12 credit hours; fee: $150, $75 physicians-in-training; contact: Director of Continuing Medical Education, Cleveland Clinic, 9500 Euclid Ave., Cleveland 44106, phone: 216/444-5696.

TUMOR CONFERENCE: December 14, 16; St. John Hospital, Cleveland; 1 credit hour each session; contact: M. S. Farooqui, M.D., Director of Medical Education, St. John Hospital, 7911 Detroit Ave., Cleveland 44102, phone: 216/651-7000, ext. 394.



holiday season • winter vacation • investment time

Hempel Financial Corporation has an office equipment sale/leaseback plan to provide you with *immediate funds* for a variety of uses and the benefit of *100% tax-deductible payments.* For complete details and information on our other financial programs, send for our brochure by returning the coupon today, or call toll-free **(800) 421-7177**; in California, call collect **(213) 475-0304**.

Name

Address

City State Zip

( )

Phone

HEMPEL FINANCIAL CORPORATION
10880 Wilshire Blvd., Los Angeles, CA 90024



Tolinase®
tolazamide, Upjohn

Please contact your Upjohn representative for additional product information.

Upjohn

J-5695-6

©1977 THE UPJOHN COMPANY

THE OHIO STATE Medical Association

Proceedings of the Council

A regular meeting of the Council of the Ohio State Medical Association was held Saturday, September 16, and Sunday, September 17, 1978 at the OSMA Headquarters' Office, 600 South High Street, Columbus, Ohio.

Those present Saturday were: All members of the Council, with the exception of Doctors W. J. Lewis, Thomas W. Morgan, and Robert G. Thomas; Doctors John H. Budd, Cleveland, Past President of the American Medical Association; P. John Robechek, Cleveland, and Oscar W. Clarke, Gallipolis, Chairman and Co-Chairman respectively of the Ohio Delegation to the AMA; and John H. Ackerman, Columbus, Ohio Director of Health; and all members of the OSMA Staff, with the exception of Charles W. Edgar and Gail E. Dodson.

The Council expressed formal condolence to Mr. R. Gordon Moore, former executive editor of *The Ohio State Medical Journal,* and to Mrs. Moore, on the death of their daughter-in-law, in an automobile accident September 13, 1978.

The Council sent a message to Dr. Robert R. Clark, Akron, expressing concern over his illness, and wishing him well.

The minutes of the July 8 and 9, 1978 meeting of the Council **were approved.**

FINANCE AND MEMBERSHIP

Membership statistics were reported by Mrs. Wisse, and were received for information.

Dr. Williams presented the minutes of the August 30, 1978 meeting of the Committee on Auditing and Appropriations.

The Council **approved** committee recommendations concerning additional expenditure for computer hardware; supplementation of the employees' pension trust fund; a request for assistance from the Mahoning County Medical Society; acceptance of documents from Dr. Meiling with regard to copies of the original OSMA organization meeting minutes; *The Ohio State Medical Journal* contract with a regional advertising representative; a resolution to finalize the purchase of a building adjoining the OSMA property to the south; and approving the change from a two-year to a three-year lease of three automobiles.

A recommendation concerning the Thomas E. Rardin Memorial Scholarship was referred back to the Committee on Auditing and Appropriations for further study.

The report as a whole **was approved** as amended.

DEPARTMENT OF CONTINUING MEDICAL EDUCATION

The minutes of the Committee on Education meeting, August 30, 1978, were presented by Mr. Torrens and **were approved.**

Correspondence from Felino V. Barnes, M.D., Chairman of the Foreign Medical Graduates Committee of the Academy of Medicine of Cleveland, was received by the Council.

The Council asked for information on costs of existing courses for foreign medical graduates and the "pass rate" of those involved in existing courses.

GOVERNMENT MEDICAL CARE DEPARTMENT

Dr. Pfahl and Mr. Gillen reported on the work of the Committee on Cost Effectiveness, working with the Ohio Voluntary Effort.

DEPARTMENT OF ORGANIZATION SERVICES

The Council **approved** the preliminary outline of the proposed OSMA package travel and hotel plan for the Hawaii meeting of the AMA in December 1979. The dates selected were November 30 to December 6 in Honolulu and December 6 to December 11 in Maui, arriving back in Ohio December 12.

Drs. Budd and Robechek reported on AMA activities.

The Council voted to support the candidacy of W. J. Lewis, M.D., Dayton, for AMA trusteeship in June 1979.

Mr. Campbell reported on organization activities for the December AMA meeting and the November 29 meeting of county medical society presidents, the society executives, the officers and Council of the OSMA, and the chairman (or co-chairman) of the AMA Delegation. Registration will open at 12 Noon; luncheon will be served at 1 PM, and the meeting will begin at 2 PM.

Physicians Insurance Company of Ohio

The Physicians Insurance Company of Ohio fiscal report was presented by Mr. Campbell for the information of the Council.

Physicians Life Insurance Company of Ohio

The Physicians Life Insurance Company of Ohio report was presented by Mr. Campbell for the information of the Council.

DEPARTMENT OF HEALTH EDUCATION

The immunization campaign of the Statewide Advisory Committee on Immunizations for pre-school and school-age children was reviewed by Mr. Clinger and Dr. Ackerman. Mr. Clinger commented on the success of the

(continued on next page)

Proceedings *(continued)*

program and assured the Council that the committee will continue its efforts.

Outstanding Team Physician Awards Program

Mr. Clinger asked the assistance of the Council in seeking candidates for the 1979 Outstanding Team Physician Awards.

Physician Effectiveness Program

Mr. Clinger reviewed the progress of the Physician Effectiveness Program.

DEPARTMENT OF FEDERAL LEGISLATION

The Department of Federal Legislation report was presented by Mr. Page.

HR 13740, Conable, the "Tax Reform Act for Non-Profit Organizations" was approved in principle.

DEPARTMENT OF STATE LEGISLATION

The report of the Department of State Legislation was presented by Mr. Mulgrew.

Mr. Mulgrew discussed the councilor district meetings and their importance to the OSMA legislative program.

A number of state legislative issues were discussed by Mr. Mulgrew, including: H.B. 1118, affecting coroners; S.B. 349, the certificate-of-need bill; and S.B. 202, hospital patients bill of rights.

OHIO STATE MEDICAL BOARD

Dr. Clarke discussed rules change hearings of the Ohio State Medical Board.

He asked that physicians turn their continuing medical education logs in as soon as possible in order that processing may begin on recertification.

DIRECTOR OF HEALTH

John H. Ackerman, Director of the Ohio Department of Health, addressed the Council.

Severe financial problems with the crippled children's program were reported by Dr. Ackerman, necessitating possible reduction in services.

He announced that Bryan A. Rogers, Administrator of The Toledo Hospital, is a new member of the Public Health Council.

FIELD SERVICE DEPARTMENT

Mr. Holcomb presented the Field Service Department report.

He indicated that the physician location or placement activity of the department has increased substantially.

The Department will attempt with physicians in their first or second year of residency to increase supply of potential placements.

COMMUNICATIONS DEPARTMENT

The minutes of a meeting of the Committee on Public Relations on September 13, 1978 were presented by Ms. Doll.

A proposal for speaker training seminars was approved.

Ms. Doll and the Department of Communications were commended by the Council for the good work on the OSMA publication *Synergy*.

SUNDAY SESSION

Those present Sunday, September 17, were: All members of the Council except Doctors Lewis, Morgan, Thomas and C. Edward Pichette; OSMA Staff present, Messrs. Page, Gillen, Mulgrew: Guests present, Dr. William R. Schultz, Wooster, and Messrs. James E. Pohlman, OSMA Legal Counsel, and John Hartranft, MAI Legal Counsel.

CLOSED SESSION

The Council met in closed session.

The Council then reconvened in regular session and voted to reaffirm its action at the last Council meeting continuing its guarantee of a $75,000 promissory note by MAI on the same terms and conditions as in the previous year.

There being no further business, the meeting was adjourned.

ATTEST: Hart F. Page, CAE
Executive Director

BILLING CONSULTANTS

Summit County Medical Service Bureau

. . . has pioneered since 1967 in developing high-volume accounts-receivable management systems for hospital-based groups—radiology, cardiology, pathology.

Consulting service available to establish or to improve systems and results.

References.

Contact:

Summit County Medical Service Bureau
430 Grant Street, Akron, Ohio 44311
Telephone: 216/434-1921

Practice Productivity® Inc. Introduces

practice life

YOUR MEDICAL OFFICE MANAGEMENT REPORT

WHY practice life IS TIMELY FOR YOUR MEDICAL OFFICE.

1. We are aware and proud that the physicians of the United States offer the best medical care in the world. But never before in American history have so many negative forces been at odds with the private practice of providing quality patient care. That's why sound business principles and up-to-date procedures – that **practice life** brings you monthly and in a special annual report – are even more important today.
2. A wide range of ideas are covered. From proven scheduling techniques to how to minimize personnel conflicts. From what's new in computers to new ways to educate your patients. The breadth and scope of **practice life**'s coverage will increase your ability to make necessary decisions more quickly while being more informed.

WHY practice life IS USEFUL.

1. Presented in an easy-to-read, easy-to-refer-to format, **practice life** informs you of significant matters such as new hiring laws and contractual agreements.
2. Its high-quality data, written in precise and lively language, is effective for the medical office that cares.
3. Your time is valuable. And we won't waste a second's worth. That's why **practice life** is written as a practical guide that helps you day after day.
4. **practice life** has a distinct advantage over other sources of practice management information – a competent, full-time staff of Practice Productivity® consultants whose regular contributions come from their daily work of consulting with those of you in private practice.

WHY YOU SHOULD SUBSCRIBE TO practice life.

1. **practice life** is not for everyone. It is for those who deal with change and strive to maintain quality patient care at a reasonable cost. If that is you, order today while it is on your mind.
2. We guarantee **practice life** offers a better way to produce better results – for you. Should you decide to cancel for any reason at any time, your money will be promptly refunded on all unmailed issues.
3. The annual subscription rate of $65.00 – which equals less than 18¢ a day – entitles you to 12 issues of **practice life.** Plus an annual special practice management report.

Put another way, **practice life** is your "on-site problem-solving consultant" for slightly more than the daily postage of one mailed statement.

So send your order in immediately. Before you miss a single solution. (And your subscription is tax deductible.)

SEND ME ONE FULL YEAR OF practice life

YES, I understand that the annual subscription rate of $65 (2 years at $115) entitles me to **12 issues plus 1 annual special report.** Should I want to cancel for any reason at any time, my money will be promptly refunded on all unmailed issues.

Name _____

Name of Practice _____

Address _____

City _____ State _____ Zip _____

☐ CHECK ENCLOSED ☐ VISA ☐ MASTERCHARGE ☐ 1 YEAR: $65
(Payable to Practice Productivity®)

Signature _____

- Amount _____ • Card No. _____ Exp. Date _____ ☐ 2 YEARS: $115.
- For immediate service call 800-241-6229.

Send To: **Practice Productivity® Inc.**
Publications
2000 Clearview Avenue
Atlanta, Georgia 30340

* **practice life** is a monthly Practice Productivity® publication

Professionals Dealing with Professionals.



The insurance needs of the medical profession today requires special attention. That's why I'm proud to announce that PICO has appointed Frank B. Hall & Co. as authorized representatives for the State of Ohio. Innovative people, services and ideas are the ingredients that have made Frank B. Hall & Co. one of the largest insurance brokers in the world.

Professionals Dealing with Professionals.
PICO and Frank B. Hall & Co.

Sara A. Klempay
Frank B. Hall & Co. of Ohio, Inc.
1266 West 3rd Avenue
Columbus, Ohio 43212
614/224-5700

PICO



THE OHIO STATE Medical Association News

PICO Alters Stock Repurchase Policy

The Board of Directors of the Physicians Insurance Company of Ohio (PICO) has determined that it is in the best interest of the Company and its shareholders to no longer repurchase shares of PICO stock from shareholders. Effective October 1, 1978, this policy change was made to ensure that the resources of the Company are fully available for programs that will strengthen the Company's finances and enhance the investments of its shareholders.

The Company's stock will be traded "over-the-counter," and those physicians compelled to sell their PICO shares may wish to investigate this possibility. However, the Board of Directors of PICO hopes that each physician will retain his shares.

This action will not affect PICO's current policy regarding the purchase of stock—a stock purchase is required in order to obtain medical professional liability insurance; but no purchase is necessary for other coverages such as homeowners, automobile, and office protection.

For further information, contact the Physicians Insurance Company of Ohio, 6100 Channingway Boulevard, Columbus, Ohio 43227, telephone: 614/864-3043.

OSMA Membership Survey Coming

Within the next few weeks, OSMA members will receive a "Membership Survey" from the OSMA Membership and Long-Range Planning Committee. The survey has four major purposes: (1) to determine and to measure attitudes of OSMA members on various socioeconomic and scientific issues, (2) to develop a data base from which to formulate responses to inquiries about physician attitudes on various aspects of medicine, (3) to determine physician attitudes as to the effectiveness of current OSMA services and activities and to gather ideas for future activities and services, and (4) to gather demographic data on OSMA members.

Members are asked to take time to complete this survey and to return it at the member's earliest convenience. The OSMA needs the membership's ideas so that it can continue to provide the services needed. Look for a report about the survey in a future issue of *The Journal.*

New CHAMPUS Claim Form

The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is distributing a new claim Form 500 for physicians and other individual providers. This form replaces Form 1863-2 and should be used to report services and supplies furnished by professional (noninstitutional) providers and suppliers to CHAMPUS beneficiaries and to beneficiaries of the Civilian Health and Medical Program of the Veterans Administration (CHAMPVA).

The old claim form will be phased out over the next few months and **will not be accepted after January 31, 1979.** Immediate use of the new form is encouraged as the beneficiary portion of the form requires specific information that will enhance claim processing by CHAMPUS contractors.

Physicians who have not received copies of the new CHAMPUS Form 500 may request them from the area CHAMPUS contractor: CHAMPUS Division, Mutual of Omaha, Dodge at 33 Street, Omaha, Nebraska 68131.

Referral Available for Cases of Suspected Scoliosis

As a service to Ohio physicians and their patients, the Ohio Postural Screening Program will assist in evaluating the x-rays of children with suspected scoliosis. A part of the State Crippled Children Program, the Ohio Postural Screening Program is offering this service at no charge.

The x-ray film of the patient should be an AP or PA standing film, without shoes. The film should include the shoulder level and the pelvic crest. In addition, it would be helpful if the sex and chronological age of the patient are given.

X-ray films should be sent to: Ohio Postural Screening Program, Orthopedic Department, Children's Hospital, 700 Children's Drive, Columbus, Ohio 43205. Physicians should enclose their complete mailing address and telephone number with the x-ray film.

Nominations Sought for Cancer Research Award

Nominations are being accepted for the second annual Bristol-Myers Award for Distinguished Achievement in Cancer Research. The $25,000 award is presented annually for outstanding contributions to cancer research.

This year's recipient will be selected by a five-member panel of judges from cancer research centers at Baylor, Chicago, Johns Hopkins, Stanford, and Yale Universities. Nominations will be accepted from medical schools, freestanding hospitals, and cancer research centers until December 31, 1978. Only one nomination from each institution will be accepted. For forms and further information, contact: Secretary, Award Committee, Bristol-Myers Company, 345 Park Avenue, Room 43-30, New York, New York 10022.


A Much-Welcomed
Alternative.
Limited availabilities • Two and Three Bedroo
Condominium Suites From $62,600
SC
SUMMIT CHASE
1000 Urlin • Grandview
Phone: 486-7767
Models open weekdays 10:00am to 8:00pm;
weekends 11:00am to 7:00pm

THE OHIO STATE Medical Association Clinical and Scientific

Continuing Education Examination Article

Estrogen Therapy

Moon H. Kim, M.D.
Claude S. Hambrick, M.D.
William J. Keating, M.D.
William H. Kose, M.D.
Edwin H. Season, M.D.

Editor's Note: **Having pioneered presentation by a state medical journal of a panel discussion with accompanying Category 1 examination, *The Ohio State Medical Journal* herein presents its second such offering, "Estrogen Therapy." A physician may earn two hours of Category 1 continuing medical education credit by reading this article and completing and submitting the questionnaire on page 707. Under the chairmanship of Dr. Kim, the participants have contributed many hours of review and discussion; and *The Journal* is especially appreciative to them for their contributions to the continuing medical education of their colleagues.—*R.L.M.***

MODERATOR KIM: Recent publicity concerning exogenous estrogens and endometrial cancer have resulted in much controversy in this field and a great deal of attention to the problems of clinical use of estrogen therapy. The recent data indicate that nearly one-third of women in the United States are 50 years of age or older. Obviously, this population may require estrogen replacement therapy because of estrogen deficiencies seen in this particular age group. However, the validity of estrogen therapy still is controversial. Indications are variable and some aspects are far from clear.

We are here to discuss this important subject— not to solve these controversies, but to review the current status of estrogen therapy. Our panelists represent various fields of medicine where estrogen therapy commonly is used. We hope to cover the indications, benefits, and potential risks of estrogen therapy and how to use and monitor the therapeutic effects.

Pharmacology of Estrogen

MODERATOR: Before beginning discussion of clinical aspects of estrogen therapy, perhaps the basic pharmacochemistry of estrogens should be reviewed briefly. As you know, estrogens are groups of chemical compounds, either naturally occurring or synthetic in nature, that possess biologic activities of estradiol-17β produced by the ovary. The main biologic properties are the stimulatory effects on certain target tissues such as the uterus and vagina, the effects on bone metabolism, the effects on the hypothalamic-pituitary system, and many other metabolic effects. The activities seem to depend on the affinity to bind cytoplasmic receptor proteins in the target tissues. Among the naturally occurring estrogens, estradiol-17β is the most potent biologically. There are numerous commercial products of estrogenic drugs, of which most are synthetic and some come from animal source.

The estrogens are largely responsible for the pubertal changes in girls, growth and development of the female reproductive system and breasts, and bone maturation, and have various effects on neuroendocrine system and psychoemotional aspects. Because of their wide range of pharmacologic actions, the clinical use of estrogens varies widely. This is why controversies exist; however, the most common indication of estrogen therapy is for replacement in menopausal women.

Indications for Estrogen Therapy

MODERATOR: Let us commence by discussing the indications for estrogen therapy followed by discussions of other related problems.

Dr. Keating, would you discuss some indications?

DR. KEATING: To put estrogen therapy in perspective, let me briefly sketch all the indications for estrogen therapy, not only the menopausal one.

In pediatric and adolescent girls, estrogen is used as a replacement therapy for deficiency in conditions such as gonadal dysgenesis and hypopituitarism, and other estrogen-deficiency states. It has been advocated for use topically in the treatment of agglutination of labia minora in infants and children, as adjunctive therapy in the treatment of preadolescent vulvovaginitis, and as therapy for abnormally tall girls in an attempt to force earlier epiphyseal closures.

In the adult reproductive years, it is used in contraceptives (birth control pills) and in certain endocrine contexts for endometrial priming in the evaluation of endometrial responses if the progestin challenge test fails. Occasionally, it is used in the estrogen provocation test to provoke a rise in luteinizing hormone to prove the intact status of the hypothalamic pituitary axis, and also is used in cases of inadequate cervical mucus in an attempt to improve the quality of cervical mucus in infertile patients.

Of course, it is used in the postmenopausal woman for various aspects of the menopausal syndrome. Estrogen also is advocated for use in the prevention of osteoporosis in the elderly female.

Of these uses, overwhelmingly, the two most common uses are those in birth control pills and for the therapies in the postmenopausal woman.

MODERATOR: Estrogens also can be used in treatment of certain types of cancer, for example, prostatic cancer.

Let us limit our discussion to more widely indicated situations such as replacement therapy. It appears that we can group these indications into three subgroups: *first and most common are the symptoms related to hypothalamic and autonomic nervous system imbalance, resulting in the vasomotor symptoms; *second, the symptoms related to metabolic disturbances such as osteoporosis or the atrophic changes that Dr. Keating mentioned; *finally, psychoemotional disturbances which we see often in postmenopausal populations.

Dr. Kim, Columbus, Professor of Obstetrics and Gynecology, Chief, Reproductive and Infertility Division, The Ohio State University College of Medicine; and Attending Physician, The Ohio State University Hospitals.

Dr. Hambrick, Dayton, Assistant Professor, Department of Family Practice, Wright State University School of Medicine; and Member of Courtesy Staff, St. Elizabeth Hospital.

Dr. Keating, Fairview Park, Associate Clinical Professor of Obstetrics and Gynecology, Case Western Reserve University School of Medicine; Chairman, Department of Obstetrics and Gynecology, Fairview General Hospital; and Associate Visitant, Cleveland Metropolitan General Hospital.

Dr. Kose, Findlay, Specialist in Internal Medicine and Staff Member, Blanchard Valley Hospital.

Dr. Season, Columbus, Assistant Professor, Department of Surgery, Division of Orthopaedics, The Ohio State University College of Medicine; and Staff Member, The Ohio State University Hospitals and Children's Hospital.

Estrogen Therapy discussion held April 15, 1978 at OSMA Headquarters, 600 South High Street, Columbus, Ohio 43215.

Vasomotor Symptoms

MODERATOR: Perhaps, problems of the vasomotor systems, such as "hot flashes" and sweating, are the most disturbing and common indication for estrogen therapy in practice. Does anyone believe that all patients with such symptoms need actually to be treated?

Dr. Hambrick, how would you feel about it?

DR. HAMBRICK: Just like any other problem in medicine, we have to think of underlying cause. There are some other causes of "hot flashes," and we have to be careful we are not trapped into thinking that every 55-year-old female with "hot flashes" has an estrogen deficiency. An example of another cause is thyrotoxicosis.

The symptoms would be the principal item in my differential diagnosis. However, clinical evaluation of the patient such as appearance of the vaginal mucosa, other findings on physical examination, and history of menstrual periods should also be considered.

MODERATOR: You are saying the diagnosis has to be established as an estrogen deficiency causing the vasomotor symptoms. Dr. Keating, would you agree with that?

KEATING: Entirely. The moving force is the patient's complaint. I know of very few responsible physicians who on their own, would initiate therapy with no complaint from the patient. Then it becomes necessary to establish that complaints really mean the patient is suffering from estrogen deficiency and that replacement of the deficiency would relieve the symptom.

Since it is now obvious that estrogens provide both "good news and bad news," it becomes necessary to decide at what intensity or at what level of disruption of a woman's lifestyle it becomes wise to intervene and use estrogen therapy.

MODERATOR: Even with the vasomotor symptoms, we have to establish a diagnosis of estrogen deficiency first and then use estrogen therapy selectively.

Psychoemotional Problems

MODERATOR: Does anyone prescribe sedatives or tranquilizers in questionable cases? (You are not sure that the patient has an estrogen deficiency that is causing "hot flashes.") Oftimes, I find patients have been prescribed a tranquilizer sedative for a long period of time. Do you think this sort of therapy would benefit or potentiate the estrogen therapy?

KEATING: Basically, it is "relatively easy" to identify patients who are involved in one or another emotional problem or a mood, or more intense psychiatric problems. It is not an exclusion diagnosis. With time, it usually is possible to determine that these people are not just estrogen deficient but are suffering from psychologic problems.

HAMBRICK: I prefer to talk with the patient and discuss her problems. For example, take a depressed patient. Maybe the estrogen deficiency is aggravating the depression, but perhaps it is not causing it. With a situa-

tional depression, perhaps she will need an antidepressant for a period of time.

MODERATOR: We should find out if the psychoemotional factors are responsible for symptoms because women often can complain of what sound like "hot flashes," but may not be due to estrogen deficiency. Obviously, such a patient does not need estrogens.

Perimenopausal Problems

MODERATOR: We have been talking now primarily about postmenopausal women. What about the perimenopausal age group? Often times, a transitional period of six months, one year, or a year and a half precedes menopause, during which time the patient may complain of "hot flashes" and some other vasomotor symptoms. Do you treat these patients in the same way as for the postmenopausal women?

KEATING: No, not precisely the same way. My criteria for treatment would differ.

Essentially, most women who are having episodes of endometrial bleeding are producing enough estrogen. If I have ruled out nonendocrine reasons for that bleeding, then supplying more estrogen to them is not likely to add anything beneficial to their health or economy.

Most of the time, the doses of estrogens that I prefer to aim at my patient's well-being are sub-bleeding doses in the first place; and I am rarely happy to add further estrogen to a woman who already is bleeding regularly. If, however, I have to treat a woman with estrogens, I will treat peri- and postmenopausal women essentially the same way.

However, some women can enter a period that looks like true menopause. It can last for six or eight months with typical, classic vasomotor symptoms, and obvious evidence of estrogen deficiency. Then the woman begins to menstruate for six more months.

MODERATOR: Sherman and Korenman found this to be true when following perimenopausal subjects longitudinally over a period of one year, and a year and a half. The gonadodropin levels are elevated and the estrogens are low for two or three months, then they revert to the normal range. The subjects start having ovulatory cycles for one or two cycles; and eventually, they reach the true menopausal state. I think we have to recognize this entity before instituting estrogen treatment.

HAMBRICK: Dr. Keating, how often in the perimenopausal period is progesterone deficiency the real problem? Do you sometimes try a progestogen for awhile where there is some problem with either continuous bleeding or irregular bleeding?

KEATING: Yes. The perimenopausal woman may make continuous estrogen at stimulatory levels for the endometrium; and because she is not cycling with progesterone, she simply enters a phase of estrogen breakthrough bleeding which is difficult to control. By and large, this is my indication for the use of progesterone. The woman should be clearly free of malignant changes or other local conditions and should be bleeding from the proliferative endometrium because she is not ovulating.

HAMBRICK: That implies that you would do an endometrial biopsy?

KEATING: Because some women have such classic symptoms, I am willing to start a trial of progesterone therapy of some form without prior checking. However, this does not apply universally. Most of these women actually bleed in alarming amounts to themselves, and we frequently initiate the therapy of dilation and curettage to stop the bleeding.



Moon H. Kim, M.D.

MODERATOR: I disagree slightly. Anytime I am dealing with a perimenopausal patient who has irregular bleeding, whether this is a part of her physiologic changes during the transitional period or not, I would be reluctant to put her on progestins unless I know with what I am dealing.

How would you rule out malignancies and other pathologic conditions?

KEATING: My routine for the patient is endometrial biopsy. But many of these patients really are candidates for dilation and curettage because of the amount of bleeding they are having.

MODERATOR: Since the progesterone phase only exists when ovulation takes place, it is not always a deficiency state but rather a lack of ovulatory cycles— anovulatory state.

What about the problems of the internists who have patients with menopausal or premenopausal problems?

DR. KOSE: Treatment for these patients depends on the symptomatology that someone may present. From what I see in medicine, the menopausal syndrome begins somewhere after age 30 years until the female may become 60 years old. There are a multiple number of complaints that may be related to menopause.

I do not do any primary gynecology from the standpoint of treatment or diagnosis, but I think that the public and many physicians falsely consider menopause to be a disease state. I find it helps to talk to patients about these symptoms and stress that menopause is a natural part of a life cycle.

Women are very aware of the complications and are not as interested in taking medications as they may have

been previously. In fact, everyone who has a definite estrogen lack may not need to be treated. I have seen many vague complaints and many real complaints that have responded to estrogen therapy from a medical and not gynecologic standpoint. But however, it is rather difficult to sort these out and say they have improved from estrogen therapy.

Cardiovascular Problems

MODERATOR: One of the major controversies surrounding estrogen therapy other than cancer and osteoporosis, which we will discuss later, is its implication to coronary heart disease. Do you think there is evidence of increased incidences of coronary heart disease associated with menopause?

KOSE: Statistically, I think the original data indicated that estrogen had a protective effect on the female because of the diminished number of myocardial infarctions and other symptoms of coronary heart disease. I believe this theory arose from just looking at raw data, possibly without considering other reasons why there might be a diminished incidence of heart disease in women.

Statistically, if you analyze different studies of the female with hypertension, underlying problems with lipid abnormalities, and other symptoms that may be risk factors in heart disease, there is no evidence that estrogen decreases the likelihood of coronary heart disease or myocardial infarction.

MODERATOR: Dr. Keating, often times in gynecology we have to do bilateral oophorectomies in premenopausal women. When you follow these patients and gonadal dysgenesis patients for a long period of time, do you find these people tend to develop heart disease more often than the unoperated menopausal patient?

KEATING: From my own experience, I cannot say that there is *more* heart disease, but these operated women tend to develop it at earlier ages than their contemporaries. One of the problems with some of the studies mentioned by Dr. Kose (referring to the original thought two or three decades ago that estrogen might be protective) was that the studies were based on a fallacious collection of data: only middle- and upper-class Caucasian women have less heart disease than their male contemporaries. It now is known that the Black woman is not so protected, at least in this country. Another fallacious assumption in those studies was that the only difference between the male and female was estrogen, which obviously is not true.

MODERATOR: There are many studies, controversial at best, in which autopsy and all its retrospective findings were applied. Some studies have shown that in women who had premature ovarian failure or premenopausal oophorectomies, more coronary disease was found on autopsy. This supports some of the old concept, but, not too long ago, Ritterband, et al have followed the retrospective studies. Having examined 200 to 300 patient populations (including 200 patients with total hysterectomy with bilateral oophorectomies, as compared with the control group who had simple abdominal hysterectomies, and followed these populations some 15 to 25 years, they concluded that neither group had significantly more coronary disease than the other.

Therefore, we do not deal necessarily with tremendously increased incidence of heart disease, perhaps because we start these people on the estrogen therapy earlier. As long as estrogen is provided, increased heart disease may not occur. But again, estrogen is not the sole factor.

KOSE: Conversely, the coronary drug project quoted by many showed that there was a much higher incidence of coronary heart disease when estrogen was used in high dosages in men. In fact, the incidence was so high that the high dose treatment program was discontinued.

MODERATOR: However, a lower estrogen dosage did not make much difference.

KOSE: Yes, they cut the dosage in half and concluded that there was no evidence of increased incidence of coronary disease.

MODERATOR: But, is it true when you are dealing with a naturally menopausal population? Don't they have a high incidence of coronary disease after menopause?

KOSE: Yes, they do; but I think that you must consider all of the other effects on coronary heart disease including what happens to the blood lipids. Usually, the effect of estrogen is to increase the phospholipids and the triglycerides. I have read different opinions about what may occur with the cholesterol. Cholesterol may behave in different manners, but the natural happening with postmenopausal women is that cholesterol increases with little change by adding estrogen. In addition, hypertension occurs more frequently after menopause.

MODERATOR: In relation to coronary heart disease, the sex advantage of the premenopausal female to a low incidence of coronary heart disease— as compared to her male counterpart— disappears after the menopause.

KEATING: That is right.

HAMBRICK: Dr. Burch and his group at Vanderbilt studied 1,000 women with ovarian failure due to castration or natural menopause. This study covered 14,300 plus patient years or an average 14.3 years per patient. Speaking only of the heart conditions and the anticipated deaths from heart disease during the time study period, the anticipated number of deaths from heart disease would be 35, and the observed was 13. This suggests a protective effect of estrogen since these patients were on estrogen therapy.

MODERATOR: I think it is important for us to address the current status of the so-called preventive effects of estrogen as they pertain to coronary heart disease.

KOSE: What you are saying is that a protective effect is achieved by treating premenopausal women without ovarian function with estrogen. However, beginning estrogen therapy on patients with a normal menopause, perimenopause, or postmenopause, does not change the course of arteriosclerotic heart disease?

MODERATOR: Yes.

KOSE: I will agree with that.

KEATING: Basically, I would agree. As far as I can see, estrogens tend to do all the wrong things in these women. Estrogen therapy is not good for the diabetic. It contributes to hypertension that would not otherwise be there. The clotting factors are altered in favor of superclotting. It also has been found to elevate triglycerides.

Contraceptives

MODERATOR: We should spend a moment considering the relationship between contraceptive pills and coronary heart disease because the subject has been very controversial recently. As you know, most of the recent data, primarily from England, and some of the Food and Drug Administration (FDA) newsletters recently circulated, suggests that the risk factor of myocardial infarction in women using oral contraceptives would be two or three times higher in the age group of 30 years to 39 years and about 5.6 or 5.7 times higher in the age group of 40 years or older than in the under-30-year woman. If the 40-or-older age group are smokers, the risk goes higher to about nine times.

We all remember that when birth control pills first became available in the 1960s, everybody thought this was great medication, conveniently packaged for the patient's use. In addition to the use for birth control, I still see some patients on conventional birth control pills for relief of hot flashes.

KEATING: I certainly do not believe birth control pills should be used for replacement therapy. You mentioned the age-related problem with the birth control pill and cardiovascular disease, but it is dose-related, too. At least the English studies clearly show that it is dose-related. If these studies are correct, the birth control pill provides massively too much estrogen. There is no need to give a woman 50μg of ethinyl estradiol just to relieve "hot flashes."

MODERATOR: I suppose what happened generally is that women were prescribed the Pill during the perimenopausal age or for regulation of irregular bleeding after dilation and curettage, but someone forgot when to stop prescribing it. Birth control pills should not be used for the purpose of estrogen replacement, and the estrogen dosage of the conventional birth control pills is too high to be safe in the perimenopausal age group.

KOSE: Do you prescribe birth control pills for patients over age 40 years?

MODERATOR: Almost never now. However, we used to until about two or three years ago. I would not recommend birth control pill use in the age group of 40 years or older for whatever the indications.

KEATING: I also find it hard to argue with the epidemiologic studies, although I am always a little skeptical about any data out of England that deal with clotting problems because, for some reason, women in England clot a lot more than North American women. At the time this information became available, I had perhaps 15 or 18 women over age 40 years taking oral contraceptives. I simply presented the women with this information and my recommendations to stop. However, when I was able to tell them only as much as the FDA's computations could show us (that the risk might be somewhere in the range of 1 per 1,000 per year increased risk of myocardial infarction [*FDA Drug Bulletin,* 5:10, July-Aug., 1975]), three of those patients said: "Fine, thank you, you have told me, but I want the Pill anyway. I want to be pregnant less than I am worried about heart disease." However, one of those had a strong family history of sudden death from coronary disease; and I did manage to talk her out of the Pill after a few more months. It seems to me that since nothing magic happens at age 39, 40, and 41 years, the risks are not that different except on statistical charts. I am unwilling to refuse flatly to provide a woman with the Pill a little bit longer if she knows the risks. However, in the next few years, medical science could alter this opinion.

MODERATOR: Of course your decision depends on the patient's acceptability of other alternative contraceptive methods for her age group. I agree with you, there is but 365 days' difference in the ages of 39 and 40 years. I do not think it makes that much difference if you compare the 39-year-old group and 40-year-old group, but the statistical data show that there is a distinct difference between age groups.

Osteoporosis

MODERATOR: Let us consider the other metabolic disturbances commonly seen in estrogen deficiency, namely, osteoporosis. Various published data suggest that about one out of four Caucasian women over age 60 years has spinal compression fractures due to osteoporosis, and that about 80% of all patients with a hip fracture have preexisting osteoporosis. Because of these findings, estrogen deficiency has been implicated, at least as the cause of postmenopausal osteoporosis and all the pathologic fractures. Naturally, estrogen has been used in such cases for prevention or treatment of osteoporosis with, at best as I can see, controversial results.

DR. SEASON: Most orthopedists have a rather large segment of their practices composed of elderly women with fractures. These fractures include the Colles' fracture or the fracture of the distal radius, which is the most common fracture seen in the emergency room; or the hip fracture, the most common fracture requiring hospital admission. These two fractures and the vertebral collapse fracture are pathologic fractures due to osteoporosis.

We know that after menopause, women lose bone at the rate of about 1% or 1½% per year. As a result of bone loss, there are 50 to 70 fractures per 1,000 women occurring each year. By the age of 90 years, 40% of all women have sustained a hip fracture.

MODERATOR: Is estrogen the most important etiologic factor of postmenopausal osteoporosis?

SEASON: I think there's no question about that. A few factors that seem to be related to the development of osteoporosis include sex, race, castration, activity, size, and weight of the patient. It is clear that estrogen must be a major factor when one considers that the majority of the so-called pathologic fractures occur in women. (There is a very low incidence in men. Men do lose bone in their later years, but not nearly at the rate that women do; and as a result, they do not show the frequency of fractures seen in women.)

Race is a very important factor in that Black patients do not sustain these pathologic fractures as frequently as lighter-skinned people. Castration also is a major factor. Women that undergo oophorectomy in their late 30s or early 40s may develop profound osteoporosis.

Activity is a factor. Activity will stimulate bone formation and prevent the bone loss that occurs in the elderly.

Finally, size and weight seem to be significant factors in that osteoporotic women usually are not necessarily heavy. These women are usually small, thin individuals. So, if one positive thing can be said about obesity, it is that it may prevent or retard the development of osteoporosis.

Clinically, patients with osteoporosis complain of back pain, usually as a result of vertebral collapse. They may develop kyphosis; they may have loss of height from multiple vertebral collapse.

MODERATOR: Why do obese patients tend to have a lower incidence of osteoporosis? I think there is some endocrinologic evidence that obese patients tend to produce a little more estrogen, mainly estrone, in the postmenopausal period by using the precursor hormone. We see obesity as a really bad part of general health because these women tend to have more postmenopausal bleeding, and they will have a higher incidence of cancer and other pathologies.

KOSE: Maybe they are just ingesting more calcium.

MODERATOR: Recent studies indicate that vitamin D and calcium are important. But it appears that estrogen has some permissive role in the process of osteoporosis.

SEASON: Also, stress on a particular bone will cause it to become stronger. That is Wolff's Law in orthopedics.

KEATING: You mentioned both of the factors. The first is peripheral conversion of adrenal precursors to estrogen; the fatter woman simply makes more of her own endogenous estrogen. The second is that overweight women, by and large, are at least ingesting the minimum requirement of various nutrients.

One of the problems that occurs at menopause is that when estrogen levels drop, there is a higher scavenging of calcium from bone. There is a greater output and less reabsorption of calcium in the renal tubule, and the gut produces less of the active forms of vitamin D. All of these things simply mean that the woman is wasting calcium; but presumably, she can protect herself if she takes in enough calcium orally.

MODERATOR: In essence, estrogen tends to decrease the calcium clearance from the kidneys, thus resulting in positive calcium balance.

KEATING: Reabsorption. I believe maintaining estrogen therapy in women at risk will prevent, not reverse, osteoporosis. Estrogen stabilizes the bone. In some way, it prevents parathyroid hormone from scavenging calcium.

KOSE: How did you define women at risk?

KEATING: Since osteoporosis almost does not occur in Black women in this country, if we could identify the 25% of Caucasian women at risk, they would certainly be justifiable candidates for estrogen for life. This is the feminine-forever theory that Dr. Wilson and colleagues were publishing about 15 years ago. Although prolonged estrogen therapy is probably a bad idea for persons not at risk of osteoporosis, I know of no way to eliminate them in advance.

SEASON: The data show that estrogen therapy in patients with osteoporosis will prevent future bone loss. The big question is whether it actually will reverse the process and produce increased bone mass. Most people feel it does not increase bone mass and will not result in increased bone mass. So, from that standpoint, we are in somewhat of a dilemma because we identify the patients with severe osteoporosis after they have lost all their bone mass; and it probably is too late at that time.



LEFT: **Edwin H. Season, M.D.**
RIGHT: **Claude S. Hambrick, M.D.**

MODERATOR: I think what you are implying is actually you cannot reverse the aging process, but you can slow down or perhaps even prevent it.

SEASON: The negative aspects of it. But, on the other hand, the castrated woman is someone we can identify at risk. Estrogen therapy is efficacious in this situation.

HAMBRICK: A prospective study was published in *The Lancet* (1976). Sixty-three castrated females were treated with estrogen, and 57 castrated females were treated with placebo for five years. The bone mass did increase in the treated group as compared to the placebo group.

KEATING: The only studies I am familiar with which considered evidence for increased bone mass are the densitometry studies, which were negative. I am familiar with only one other, the Aitken study in the *British Medical Journal* (1973). They showed a protective effect in cas-

trates only if their treatment was started within three years of castration. After that, the protective effect was lost; and they continued to develop osteoporosis thereafter in spite of estrogen therapy. So there seems to be a time element as well as an age element.

KOSE: Using the densitometer, I understand the feeling was that, in general, bone loss probably was accelerating or beginning well before menopause, age 35 years or so. Now, do you think this is a change that we do not pick up hormonally?

KEATING: I do not think it starts at age 35 years. This is not an area I work with every day, you understand, but most of the people whom I have used as authorities seem to feel that *peak* bone mass and density in both sexes occur around the age of 35 years, but before age 50 years, which is the usual median menopausal age today.

MODERATOR: Again, this may be related to the physical activity that Dr. Season mentioned because obviously, individuals who have reached age 35 or 40 years, may not be as active as someone 25 years old.

Dr. Season, what about the treatment for the established care of osteoporosis? You have a patient who is complaining of back pain and who has no fractures. This type of patient often is seen in gynecology practice, and I am sure Dr. Hambrick sees similar cases in general practice. You take x-rays and find clear evidence of osteroporosis. How would you treat her?

SEASON: The first thing that you have to determine is whether osteoporosis truly exists. Even though there may be a rather characteristic radiographic picture, there are clinical syndromes that can look very much like osteoporosis, such as osteomalacia. When one has a compression fracture of the spine, so common in osteoporosis, this could also represent a pathologic fracture from myeloma or metastatic disease to the spine. So, when we think about treatment, we have to be sure of the diagnosis and not be lulled into thinking that this is osteoporosis because it is the most frequent problem presenting in this fashion.

When the diagnosis of an osteoporotic spine fracture is made, we are in an ironic situation because the usual treatment for fractures is immobilization, but we do not want to advise this for the patient with osteoporosis. So we must take a balanced approach; we immobilize the patient for comfort, but not so much that the osteoporosis continues.

Medicinally, there is an option. I say an option because the data is just not clear currently as to what is effective in the treatment of osteoporosis. The option is a combination of calcium chloride, 50 mg a day, and vitamin D, 50,000 units three times a week. This is our usual medication at Ohio State University, developed by the school's internal medicine endocrinology division.

As to whether these patients should receive estrogen, the decision should be individualized to the patient with consultation from physicians authoritative in the use of estrogens.

KEATING: We will also refer the patient if she is highly immobilized.

Most of the information available in this area deals with the management of the fracture syndrome, not the bone loss syndrome. Usually, by the time we know that the patient has bone loss, she's had her first major fracture. Treatment with estrogen for bone loss after fracture can only be palliation, for you are hoping to stabilize the skeleton at that point and not let it get worse. If you had an agent which actually reversed the osteoporotic process and increased bone mass and density, you would want to avoid estrogens; they would prevent such an agent from rebuilding bone matter.

As to the protective effect of estrogen, there again, most of our studies mainly show the effect on preventing bone loss. I am aware of no competent study that indicates we can prevent fracture. Nobody has really looked at that question. So, most of the studies that we have, although the bone picture seems clear, really are still speculative regarding fracture prevention.

MODERATOR: If the therapeutic goal is palliation or you identify the high risk population for development of osteoporosis, such as young castrated women or a young girl with ovarian failure, then estrogen may be of great help; but if it is therapeutic and the goal is to reverse existing osteoporosis, then you do not think it would be beneficial.

KEATING: If you had an agent that would reverse osteoporosis, you would not give a patient estrogen because that would stop the reversal.

SEASON: We should consider what effect the trend on jogging and physical activity will have in the future. Physical activity is becoming quite popular for even middled-aged and some elderly patients, and I feel that this is probably one factor that may have a protective effect.

Endometrial Cancer and Estrogens

MODERATOR: There are numerous biologic effects of estrogen, but perhaps its growth-promoting effect on certain target tissues, particularly endometrium, has caused the most controversy over the use of estrogen. It is a relatively well-known fact that when patients are chronically stimulated with estrogens, they tend to develop endometrial hyperplasia followed by carcinoma. Even young patients, who are not ovulating regularly but are under chronic estrogen stimulation, tend to develop endometrial hyperplasia; and eventually they can develop endometrial cancer.

Since we used estrogens widely in the 1950s and 1960s as a "female forever" type of concept, one controversial issue concerns an increased incidence of endometrial carcinoma reported in the last few years.

Do you believe that there have been more cases of endometrial cancers in the past four or five years?

KEATING: I think it is hard to dispute the weight of the studies that show we are dealing with increased incidence, although it is not hard to pick holes in any one of them.

The whole question is complicated by the fact that in dealing with the carcinogenicity of drugs, you cannot truly answer the question by clinical studies except in the most extreme of cases where virtually every exposed patient is going to develop a malignant tumor. Most of the time, you have to rely on epidemiologic studies; and those statistics can prove anything you want.

The studies that really speak to this question and have convinced me are the case-control studies that, while retrospective, nevertheless seem to be very well chosen. Of course, the FDA has made a great deal of these cases. I am speaking of the studies by Smith et al, Ziel et al, and Mack and his associates, all published in the *New England Journal of Medicine* at various times during 1975 and 1976. The first was a 94-patient study in California completed by Ziel and Finkle. Ninety-four women with endometrial cancer were compared with 188 controlled women (two controls for each patient). Controls were selected from the same health plan population and were matched for age, duration of the health plan membership, area of residence, and potential for the development of endometrial carcinoma. According to the outcome of this study, the estimated risk ratio for endometrial cancer was 7.6 times higher overall for women taking estrogen. In this study it clearly was related to the duration of the estrogen use. The range was from 5.6 for women who had used the conjugated estrogens for less than five years to 13.9 for women who had used them over seven years.

The second study, by Smith et al, is a study of 317 patients from Seattle who had endometrial cancer. They were compared with an equal number of control patients from the same institutions who had cancer but not endometrial cancer. Subjects also were matched for their age, diagnosis, and year of diagnosis. In this study, the increased risk of endometrial cancer among estrogen-exposed women was 4.5 times higher.

The third case control study was in a Southern California retirement community, with an estimated risk ratio in this group of 8.0 times increase for estrogen use. This study reported a difference in the degree of risk directly related to dosage.

In addition to those studies, there are studies which indicate that in most of the reporting states, in figures from 1969 onward, there appears to be an absolute increase in the number of cases of endometrial carcinoma being reported. This shows a very interesting time lag from the sudden explosion in the use of estrogens starting in 1965. Of course, the real common denominator to use here is not the total number of women, but the total number of women who have a uterus; because if there is no uterus, the disease cannot be there. Hysterectomy data seem to show that the number of hysterectomies has been increasing. The obvious increase of endometrial cancer in 1969 may be in the face of a decreased number of women at risk. Therefore, the portion of the population with endometrial cancer may be even larger than it appears.

Putting that all together, I think the weight of the evidence makes it hard to argue that estrogen in some way contributes to endometrial carcinoma.

MODERATOR: I agree with you, and I think the argument is that all of these studies suffer from retrospectiveness. But it is very difficult to deny the significance and implications brought out by these studies, so we have to look at them carefully.

KOSE: In that data, are there any subgroupings as to how the estrogen was given, dosage, for example?

KEATING: Dosages are analyzed in two of the studies. In both studies, there is an indication that an increase in dosage causes an increase in risk. In the other study, this increased risk was overwhelmed by the effect of increased time. There was a change, of borderline statistical significance, but the time factor dominated.

MODERATOR: Unfortunately, these retrospective studies, at least of Smith and Ziel, did not have any information on the dosage and how it was given.

KEATING: That is all the studies classify with one exception: in one of the studies, virtually all of the patients were on conjugated equine estrogens (Premarin®).

HAMBRICK: How about progesterone? It is important to know if the patients had estrogen combined with progestins.

KEATING: It is important, but these studies did not mention that. I see some women as being at high risk of developing endometrial cancer, and, therefore, they are not candidates for estrogen therapy. Even if you do not give them estrogen, some women are at high risk from their own endogenous estrogens. Of course, I am speaking of the woman with polycystic ovary disease whose continuous estrogen or chronic anovulatory state places her at high risk for endometrial carcinoma if not treated. Also, there is no question that women are at high risk if the time of exposure increases. Women whose menarche started very early and whose menopause ended very late already have more years of exposure to their own hormones than women who had a much shorter span of time. On an epidemiologic basis, obese women are clearly at high risk of endometrial carcinoma. They are producing endogenous estrogen at higher levels later in life.

MODERATOR: But in the Smith study that you quoted, what is more striking is that some of the high-risk factors, such as hypertension and obesity, did not seem to affect the incidence of endometrial cancer when it came down to the estrogen treatment. The incidences are much higher in those who did have estrogen treatment, whether obese or not.

The duration of estrogen therapy and the dosage of estrogen may have an effect on the development of endometrial changes. If that is the case, is there any way to detect the early change of endometrium on estrogen therapy?

KEATING: There are fewer ways than we would like, because there is no effective cytological means that does not have much too high a failure rate. Tissue is required in every diagnosis.

MODERATOR: In other words, a Pap smear is not adequate.

KEATING: Nor are endometrial washings. Every one of the techniques involving cytology from the endometrium has failure rates that are unacceptably high.

At the moment, the diagnosis must be made by obtaining tissue from the endometrium. It need not be done as a dilation and curettage under a major anesthesia since it is possible to get at least 96% correct diagnosis by endometrial biopsy without anesthesia.

Breast Cancer

MODERATOR: Are there cancers of any other organs, such as breasts or vagina, that have special association with estrogen therapy?

KEATING: As far as the breast is concerned, everyone has been worried historically about breasts because the same theoretical considerations exist for breast cancer as for endometrial cancer. They are parallel. They are made up of estrogen-receptive or -responsive tissue.

But there are some added complexities in breast cancer. One is the complexity added by prolactin. Prolactin is important for breast cell stimulation, and it is difficult to sort out the influence or role of prolactin from estrogen because prolactin is dependent in part on estrogen.

In addition, epidemiologic studies in humans, at least, will permit certain statements. First, no proof has been found that estrogen use by postmenopausal women has increased the risk of breast cancer. That is not quite the same as to say it does not, but no evidence has been found. Nevertheless, if you remove ovaries before the age of 35 years, there is a 70% reduction in the incidence of breast cancer in older women. Furthermore, if there were no endogenous estrogen in women, women's breasts would be no larger than men's and would be just as free of cancer as men's breasts. So there seems to be no question at all that estrogen plays a role, but estrogen administration does not seem to show a correlation.

There is no current association to breast cancer evident from the use of oral contraceptives, at least for short-term use. Estrogen in that form for periods of at least four years or so has not been correlated with breast cancer.

KOSE: Does it make a difference if the patient has cystic mastitis or had problems before with breast disease?

KEATING: It certainly makes a difference in the incidence of breast cancer, but I am not aware of any evidence that estrogen therapy makes a difference provided the groups have been separated for study.

HAMBRICK: To me, breast cancer is a much bigger problem than carcinoma of the endometrium. I cannot remember more than two or three cases of endometrial cancer in my whole practice, but I can remember all kinds of breast cancers. Therefore, when speaking about a total population, you have to be much more aware of the potential problem and examine older women very carefully.

MODERATOR: The other very rare, estrogen-related cancer is carcinoma of the vagina. As you know, the female offspring born to mothers who have been treated with estrogen can develop very rare vaginal cancer. So, pregnant women should never be given estrogens under any circumstances.

Patient Package Inserts

MODERATOR: Currently, the FDA requires drug companies to furnish a package insert for each product. When you prescribe estrogens, do you tell the patients to read the insert, or do you explain what that insert indicates?

KOSE: I encourage the patients to read inserts. I try to pick out questions I think they may have before they read the insert; and I try to explain the material contained in the insert. Of course, I think any explanation of a medication weighs the advantages versus the disadvantages. I try to help the patient in a decision-making process. Some people may disagree, but I think it is a good idea to have package inserts.

MODERATOR: How would you approach that, Dr. Hambrick?

HAMBRICK: I think package inserts tend to frighten patients. I do not necessarily encourage patients to read them. I realize that patients will be reading many things, but I would rather talk to them in my own language. I would rather explain risks in my own words than those of the package inserts. I really think in the package inserts, the language is designed more for the physician to read than for the patient.

MODERATOR: I think we should give patients some explanations, but I always remind the patient that the inserts are there for more information. If patients have any questions, they should return to their physicians.

KEATING: I never bought the mystique of "feminine forever." I cannot let someone ignore nature's course. I feel a need in my practice to spend time explaining to the patient why I am not going to give her what all her neighbors are getting. It takes much less time to write the prescription; but in my opinion, it really is unsatisfactory.

In terms of oral contraceptive inserts, I actually disagree with some of the insert information; and I would rather the patient did not read the package insert.

Of course, the question is moot, because the pharmacists must, by law, hand the patient the insert with the prescription.

KOSE: I think it is important for a patient to know what he/she is receiving. I am amazed at the number of people who will stop taking a medication because of what they may read or because of what someone else tells them, whether true or false. Therefore, taking time to explain the risks to any kind of medication really is important.

Atrophic Changes

MODERATOR: The "feminine forever" concept is usually reflected by fair skin and less osteoporosis. Do we have any evidence that the estrogen deficiency is, indeed, causing the skin changes and that giving estrogen reverses the process?

KEATING: My impression is that to most patients the phrase "feminine forever" means "young forever." This is a fraud from the word *go*. You need only look at men to know that no steroid hormone keeps people young.

MODERATOR: I agree. I think that men do have some slight decline in, for example, the production of sex hormones, but not to the extent that it is seen in the menopausal woman.

I am sure that you see more older female patients with atrophic vaginitis or genital atrophy than I do. How would you treat them? I consider this to be one of the undisputed indications for estrogen therapy.

HAMBRICK: I prefer to treat them topically. I try that for a few months; and if they are obviously improved, I stop it. Then, with the proper indications, I go ahead with some oral estrogen.

MODERATOR: Do you have to consider some of the side-effects that we have discussed when you apply estrogens topically?

HAMBRICK: Apparently, a certain amount is absorbed from the vagina.

KEATING: I did not begin to know how much was absorbed until an article appeared in *The New England Journal of Medicine* recently. The study by Rigg, et al on the absorption of estrogens from vaginal routes showed that the efficacy of absorption of micronized 17β-estradiol (Estrace®) yielded blood levels of estradiol 100 times higher when administered in saline by vagina than when given by mouth. This is partly because estradiol is not well absorbed from the stomach. But the fact that such an efficient absorption was taking place from the vagina startled them. The article deals with some comparative studies and it does show that estrone cream, the conjugated estrogens (1.25 mg cream), for instance had lower levels of estrogen than micronized 17β-estradiol (2 mg cream); however, they are significant levels of absorption.

MODERATOR: It is important to remember that skin and vaginal mucosa are effective absorbers of estrogens and any steroid hormones.

KEATING: In that connection, therefore, my plea would be, if you are going to use topical estrogen, to use it a lot more sparingly than has been recommended—one administration a week, perhaps, if all you want to do is modify the vaginal membrane or the urethra, or maybe once to three times a month (once every ten days).

MODERATOR: In spite of all the controversial aspects of estrogen therapy, there seems to be little disagreement here concerning symptomatic patients in terms of vasomotor symptoms, genital atrophy, and symptomatic osteoporosis. They all are well indicated for estrogen treatment.

KEATING: Yes, with the proviso, as far as I am concerned, that the patient is disabled in some respect by these symptoms. A patient who has "hot flashes" or "night sweats" but is losing no sleep and admits that she is feeling all right except that she awakens twice a night might be a rather poor candidate for estrogen therapy.

MODERATOR: I agree. The patient must be selected on an individual basis with consideration given to various factors.

In the same line, I suppose patients with psychoemotional problems, (perhaps in the menopause) can be benefited by estrogen therapy; but, those with a truly psychoemotional background not related to estrogen deficiency certainly should be excluded.

Contraindications

MODERATOR: We can now discuss briefly some of the contraindications to the use of estrogen therapy.

KEATING: In terms of obstetrics, estrogen has no known beneficial therapeutic effect in pregnancy, and it has several risks. Another contraindication would be undiagnosed genital bleeding. A third contraindication would be breast carcinoma or carcinoma of an estrogen-dependent organ or tissue. (There are people who are not using this particular element as an absolute contraindication.)

KOSE: Could you qualify that? Many people are using hormones, depending on their estrogen receptors.

KEATING: That is right. This is no longer an absolute contraindication. Breast carcinoma which has no estrogen receptors may not be a contraindication at all.

Estrogen receptors consist of protein in the cytoplasm of the cell with which estrogen can bind selectively. There, the estrogen-bound receptors are then the vehicles by which the estrogen passes through pores in the nuclear membrane and bind to the nuclear receptor protein. Then, a hormone causes gene interaction that represents the actual function of the estrogen in that cell. Out of that interaction will come some change in the function of the cell such as the production of new proteins, or different enzymes, or whatever.

MODERATOR: The implication is that if the tissue does not have a specific estrogen receptor site in cytoplasm, estrogen will not be effective on the particular cells. Therefore, whether or not the breast tissue removed from a patient with breast carcinoma has estrogen receptors would make a difference in the choice of treatment.

KOSE: From a medical standpoint, the contraindications that I would be concerned about would be a history of any type of a clotting problem, thrombophlebitis, or any other type of thrombotic process that may have occurred. I am sure all of these would be considered absolute contraindications. Certainly, a physician would be concerned about

anyone who had had jaundice of pregnancy; she would probably have a higher incidence of becoming jaundiced. Also, there is concern for anyone who develops hypertension while on estrogen therapy. That, again, would be something to watch. In addition depending on diseased states, there are some metabolic problems that may occur, such as calcium metabolism.

In general, these are the medical problems I would be concerned about. It's probably a good idea to have a base line, certainly for blood pressure, and also perhaps for the triglycerides and cholesterol, especially if the physician is talking about birth control pills in addition to estrogen therapy.

MODERATOR: You mentioned thrombophlebitis. Does it make any difference whether the patient has a deep-vein thrombophlebitis or superficial thrombophlebitis?



LEFT: **William H. Kose, M.D.**
RIGHT: **William J. Keating, M.D.**

KOSE: The therapeutic dosage that we are employing is probably not significant in superficial thrombophlebitis.

In addition, not that you necessarily would not use the medication, but if someone tells you that she became jaundiced when she was pregnant, I think you should tell her that she has a higher possibility of becoming jaundiced.

KEATING: Cholelithiasis is one problem, and diabetes mellitus should be another condition of concern.

HAMBRICK: Any severe liver disease certainly would be an absolute contraindication.

Also, if the hypertension appeared as a result of the estrogen therapy, that could be a relative contraindication. We mentioned cholecystitis and cholelithiasis. Also pancreatitis; severe edema whether it would be cardiac or nephrogenic; and, of course, allergy to a specific preparation.

MODERATOR: Allergy to estrogen preparations?

HAMBRICK: Yes. Obviously, you would not want to prescribe an estrogen preparation if a person was allergic to it.

MODERATOR: Has anybody seen allergic reaction to estrogen preparations?

KEATING: Many people say they are allergic because they get nauseated.

HAMBRICK: That is true of many things; many times a person cannot distinguish between a side-effect and an allergy.

SEASON: One must be aware of estrogen effects on blood clotting in the elderly patients with prolonged immobilization.

KOSE: The other problem is a hypercalcemic state that might develop in immobilized patients.

SEASON: The usual patient who contracts immobilization hypercalcemia is the young patient who is actively in the process of bone formation. I would be reluctant to use estrogens under circumstances of immobilization hypercalcemia because of the risks involved. Elderly females with osteoporosis usually do not develop immobilization hypercalcemia.

Selection of Estrogen

MODERATOR: Finally, let's turn to actual treatment based on the indications and contraindications. How do you select an estrogenic preparation from all the marketed estrogens?

HAMBRICK: I use the conjugated estrogen, Premarin®. I would be more inclined to begin with a lower dose than I did 20 years ago. I used to start most everyone on 1.25 mg daily of Premarin.® I think I would be inclined to reduce the dosage to .625 mg daily.

KOSE: Usually, I would use Premarin® in approximately the same dosage. Due to my practice, I seldom initially prescribe estrogen; usually, it's more likely that I will see a patient already taking it.

KEATING: I suspect that the best estrogen to choose probably would be the least expensive one; since we have no evidence, at this point, that any one estrogen has a different cellular role from any other estrogen and all are given in equally potent dosages. Probably, if estrogens are carcinogenic, they are equally so at comparable dosages.

All my own experience has been with either stilbestrol or conjugated estrogens. But in recent years, since the stilbestrol studies in relation to the development of vaginal adenosis have been widely published, I am not using very much stilbestrol, on patient demand, even though I do not believe stilbestrol is any more or less effective.

HAMBRICK: Weren't the doses tremendously high that were given to pregnant patients whose female offspring subsequently developed adenosis of vagina?

MODERATOR: Yes. Originally, it was advocated that a patient would begin on a 5-mg-daily dosage during the very early stage of gestation; then increased the dosage to about 30 mg, which was continued to the latter part of pregnancy. These were substantially superpharmacologic dosages.

KEATING: I believe those physicians were using stilbestrol to maintain their pregnant diabetic patients (Priscilla White's regimen). Some used far larger doses to treat habitual aborters.

MODERATOR: But the dosages we are speaking of is a replacement dosage, not the pharmacologic dosage. I don't think that stilbestrol in a dosage that we normally employ would have any more of a carcinogenic effect than other agents.

KOSE: Which costs less?

KEATING: Stilbestrol costs less by far.

MODERATOR: It seems that the conjugated estrogen is the most popular. Perhaps there are two reasons: (1) it has been with us for a long time, and (2) it is labeled a "natural estrogen." As you know, conjugated estrogen, Premarin®, is derived from equine urine. So it really is not from a human source. If you look at the chemical breakdowns, only about 40% of conjugated estrogen is estrone sulfate, and the remaining portion is equine-type estrogenic compounds which are not seen in the human.

Micronized estrodiol 17-β is, perhaps, the newest form of estrogen. It is marketed under the name Estrace®. Riggs' study has been mentioned. We have made similar studies, and the breakdown of orally administered Estrace® does not seem to take place in the same way as the endogenously produced estradiol. On the other hand, if you administer this medicine through the vaginal route, the breakdown seems somewhat different. The ratio between estrone and estrodiol is close to the physiologic estrogen breakdown. So really we do not have any information as to which medicine is better.

Does anybody use parenteral administration of estrogen?

HAMBRICK: In the old days, patients would come in and "sort of" demand it because their previous doctor had prescribed it for them. They had had their injection once a month or once every two weeks or whatever, and they would just fight for it. It was almost as if the patients were addicted to parenteral administration of estrogen.

KEATING: When estrogen therapy was introduced, it made sense because the naturally occurring estrogens were absorbed so poorly that the only highly effective source was a parenteral source. However, this belief is archaic today.

MODERATOR: Today, I do not think that in most situations parenteral administration has any place in estrogen replacement therapy.

In addition, implantation of estrogen pellets is not widely accepted. We use it only occasionally for people who have absorption problems.

How to Use Estrogen

MODERATOR: Once you select the specific estrogen, how do you prescribe it? Traditionally, we give a daily dosage continuously, but the more recent trend is some cyclic administration.

KEATING: I try to use *the lowest dose* that will achieve my goal for the shortest length of time that the therapy can be employed for that goal. In addition, I prescribe the estrogens cyclically, even for women who have no uterus.

Speaking in terms of these principles, and in relation to conjugated estrogens, I prescribe what would be a three months' supply of 0.3 mg tablets. The patient is instructed to take these for 21 days in the first cycle at one per day. If her symptoms are, in effect, not controlled (I make very clear before beginning treatment that we are not trying to abolish the symptoms but merely to control them.), she has my permission, without checking with me, to double the dose in the second cycle. There are enough tablets in the prescription for that double dose for the second month. This is 0.625 mg daily.

She also has my permission to adjust the cycle. Some patients are miserable by the 6th or 7th day off the hormone, and I am willing to let them cycle the hormones with only a six-day or occasionally only a five-day break. However, there can be no less than five days off.

For the purposes of simplicity, I usually instruct the patient to take her medication in the following fashion: omit days 1 through 7 or 1 through 5 of each calendar month and take it every other day of the month until the first of the following month.

KOSE: Why do you favor cyclic treatment?

KEATING: Nature invariably cycles healthy women during their reproductive years. I haven't the foggiest notion why nature does that beyond what we know about continuous stimulation. But when you look at the blood patterns of the estrogens, the estrogen production falls to substimulatory levels every cycle at least once and for at least two days during the reproductive years. I know that I have not removed every estrogen responsive tissue by taking out the endometrium. Therefore, since I do not know that there isn't something important going on, I would prefer to cycle the patient as long as she can function on a cycling pattern.

KOSE: Do you feel that you are able to tell the patient that you have removed the risk of endometrial carcinoma? I have heard it explained to the patients: "Because we are cycling you, you do not have to worry about this problem."

KEATING: No, I never try to tell her that. As a matter of fact, that is my strongest weapon to wean her off this medication within a span of one-to-two years, or occasionally three.

MODERATOR: But I think that has an advantage in clinical practice. Not only from a physiologic point of view, but also by taking her off pills more than about three or four days you know circulating hormones are down to the base line. Also, I think it gives us a biological testing system there. If you are prescribing estrogens, ideally, you prescribe them to relieve the symptoms, but not to cause bleeding. But, if somebody has bleeding, then you may assume that the estrogen is perhaps slightly above the ideal level so that she responded by having withdrawal bleeding. In that case, I do not hesitate to do an endometrial biopsy, and then try to decrease the dosage. There is a certain incentive for taking her off of the continuous medication.

HAMBRICK: Many patients are not thrilled about the idea of stopping and starting medication, and I really am not convinced it is that important to cycle. I have a tendency to prescribe daily in the smallest dose.

MODERATOR: You mentioned earlier that adding progestational agents is beneficial.

HAMBRICK: Yes, I believe that it may be the first thing to try perimenopausally. Or are you talking about the postmenopausal?

MODERATOR: It doesn't matter what the patient population is.

HAMBRICK: The patient still may be producing adequate estrogen but would need some progesterone during the last half of the cycle. Some of the specialists I have talked with recommend this pattern, and it makes sense to me. Stopping the estrogen does not mean that the end organs still are not stimulated. So whether you give continuous estrogen or cycle it, you still have the estrogen stimulation; but balancing that with the progesterone makes more sense to me.

MODERATOR: I think it is just a matter of eventual patient acceptance. Young patients, perimenopausal patients having an irregular period while displaying some of the estrogen deficiency syndromes or symptoms, are unquestionably those you would like to cycle with a progestin so that they will have clear-cut bleeding. A 60-year-old woman may not like to have a period every month. Therefore, it is just a matter of patient acceptance.

KEATING: The patient's response to bleeding should determine cycling with a progestin.

We do have ample evidence from certain endogenous problems, the feminizing tumor and the Stein-Leventhal syndrome, that continuous estrogen stimulation over a long period of time is capable of producing changes that move toward malignancy in the endometrium. If I were going to treat Mrs. A with estrogen for the rest of her life for osteoporosis, I suspect I would cycle her with a potent progestin even if the estrogen was prescribed in subbleeding doses or subthreshold doses. The reason for this is the curious role of progestin as an antiestrogenic in connection with working with estrogen in cell cultures, and so on. Of course, estrogen was measured originally by the amount of mitotic changes that occurred in certain cells in the mouse cervix.

MODERATOR: Also, there is scientific evidence that progesterone might compete for some of the nuclear receptors in the cells.

KEATING: It's a specific change, but it is a curious one. As far as I am aware, the current understanding of how progesterone is antiestrogenic is quite different from the way Clomid® is. Clomid® actually competes with estrogen for the very estrogen receptor site, whereas progesterone has its own receptors. It binds to the DNA as estrogen does, and then reduces the production of estrogen receptors. It actually drops the number of receptors to which estrogen can bind.

Currently, I do not prescribe progestational agents because I do not treat most women for life with estrogen. But if I were treating a woman for life, I would cycle her with a strong progestin. Now, I emphasize *strong* because we have good evidence that weak progestins in the presence of strong estrogens are not effective (on the basis of our experience with sequestial oral contraceptives). I probably would use at least the daily dose of 10 mg Provera®.

MODERATOR: I use 10 mg Provera® daily for five days or seven days, depending on what the patient wants.

KEATING: But in Oracon®, which was removed from the market mostly because of the high incidence of reported registered endometrial carcinoma, the estrogen content was strong and the progestin relatively weak (*FDA Drug Bulletin,* June-July 1976, 6:26).

Timing of Estrogen Therapy

MODERATOR: If a patient comes to your office complaining of hot flashes and says that her last period was three months prior, when do you initiate the estrogen therapy?

KEATING: I think that is probably as variable as physicians are variable. As I indicated earlier, my own approach is to have the patient tell me to what extent her life is being upset and disrupted. I regard my role as at least equal parts educator and healer. I try to get her to understand that some adjustment phase is a very common, in fact, normal pattern for most women, and that all symptoms are not in themselves bad. If without leading questions she tells me that she's losing sleep, or that she is unable to function all day long at her job, or that her marriage is suffering because of dyspareunia and so forth, I start treating her right then. As soon as I know that she is having disruption, I am willing to start treating. I see no reason to make her be puritanical about this and suffer needlessly; but I would like to be sure she's really suffering, not just experiencing symptoms which she believes should be treated as those of five ladies down the street.

MODERATOR: Dr. Kose, I suppose the same type of patient comes to your office. How long would you advise that she remain on estrogen therapy?

KOSE: As has been noted, a patient should be on estrogen for the shortest period of time possible. An initial low dosage is beneficial as a therapeutic trial of whether the estrogen really does improve the symptomatology or not.

Because there are so many variables connected with the menopause, the patient may be mistakenly convinced that they will all disappear with estrogen therapy. If the symptoms don't abate, she may think "I have gone to the wrong doctor" or "I'm not on enough medication"; whereas there are other problems that are entering into the disease state.

But if a patient asks me whether she ought to continue on the medication, I usually suggest remaining on it for a year or so. Then I attempt to reduce the dosage

after such a period, trying to remove the patient from the medication.

MODERATOR: How do you determine the shortest period of time that patient needs estrogen therapy?

HAMBRICK: First of all, I always prescribe a limited amount of medication— possibly two refills— so that if the patient does not come back, she automatically will run out of medication. Although a few do that, I do not think this is the rule. Most patients will return for their appointments, and I try to see them at least twice a year (every six months). After a year or so, I try to decrease the dose to wean them off the estrogen gradually.

MODERATOR: Generally, we agree that those who are on the medication should be seen every six months.

KEATING: I also prescribe as does Dr. Hambrick, but most patients manage to be at least a month or two late returning to the office. However, this is better than if I tell them to come in every year and they appear at 16 months, which is the other alternative. So my instructions are to return every six months. I do not repeat the Pap smear every six months unless a woman is not perfectly normal; but I examine my patient every six months. This gives me a chance to keep track of her response to the medication and of other problems.

KOSE: How do you attempt to withdraw or to stop— the medication?

KEATING: I generally have patients cycle off estrogen for seven days, or occasionally, five or six. I encourage them to extend that period of time, at least once every six months and to report to me when the first vasomotor symptoms return. If a woman can go 11 days before feeling any effect, I am pretty sure I can at least *reduce* the dosage. The patient has shown me this, so I do not have to spend much time talking her into the reduced dosage. If it is clear that a woman has extended beyond the period of reasonable comfort, we wait six months. But she is given the option to keep extending the time off the medication to test herself.

This is especially true with the wide publicity about the malignancy problems. In the last three years, fully half of my patients have come in for their next checkup telling me they have taken themselves off; that they have tried this and it worked; and that they don't really need estrogen anymore. So the publicity has been a help in that regard.

MODERATOR: I also see a patient on the medication every six months. My instruction is similar to yours, but I always indicate that she should take Provera® for at least five days before she comes to see me. If she responds to Provera® by having withdrawal bleeding, I know that the endometrium was stimulated and I am ready to reduce the dosage.

Follow-up

KEATING: Follow-up procedures include breast examination; pelvic examination; bimanual pelvic; abdominal examination, with particular examination of lower abdomen and the liver; and blood pressure, with a repeat on certain blood studies once a year.

There may be additional procedures that would be equally protective. I think variations are entirely appropriate here, but I really believe that the opportunity to talk to the patient, much more than the physical examination, is the biggest single advantage to seeing her twice a year.

HAMBRICK: I agree. Of course, in family practice, patients usually speak of all their troubles. Very seldom do we see a person with just menopausal problems.

KOSE: I believe it is prudent that before beginning estrogen therapy, a physician know a patient's cholesterol and triglyceride levels, and her thyroid status. Certainly, if a patient can be categorized as "high risk" with respect to coronary disease, a physician will prescribe a lower dosage that should not affect the coronary artery disease process. As when prescribing birth control pills, I think that three to six months later those tests probably should be repeated although one would not expect there to be a major change statistically.

The most important element that you want to follow with a "high risk" patient on estrogen therapy is her blood pressure. It would be fairly uncommon for something to happen, but blood pressure is potentially the biggest problem.

MODERATOR: Dr. Keating, do you utilize endometrial biopsy as a routine procedure when a patient comes back to your office every six months?

KEATING: My patient who is on estrogen therapy undergoes an endometrial biopsy after she has been on estrogen. If her estrogen use exceeds a year, I start doing endometrial biopsy annually until she is off estrogen. Then, I do not do any more because if she has postmenopausal bleeding, I perform a dilation and curettage.

Bleeding

MODERATOR: Among the many side effects we have touched upon, the most troublesome and difficult to deal with is vaginal or uterine bleeding. There are two kinds of bleeding— breakthrough bleeding and withdrawal bleeding. How would you manage breakthrough bleeding? How do you treat a woman who is taking pills and has spottings?

KEATING: We will assume for the moment that the patient is on a dosage of estrogen with which I am comfortable. In my experience, most such patients have been on a dosage of 1.25 mg of the conjugated estrogen or more, but let's assume she is on a dose that I do not want to reduce immediately. Under those circumstances, my first maneuver would most likely be to take an endometrial biopsy if this has not been done within the previous six months. If it has been done, was normal, and was negative within the preceding six months, I would simply start oral progestin therapy in an attempt to convert her endometrial lining to secretory type.

I can expect a more thorough and certainly more physiologic sloughing if I convert this to secretory. In addition, the entire process should be over sooner than waiting for estrogen withdrawal to take place. Most of the time, withdrawal means at least 7-to-10 days of additional bleeding.

Thus, if a woman is bleeding through an estrogen-stimulated endometrium and is not shedding it, I simply would encourage her to shed it if I am sure it is not a malignancy.

HAMBRICK: If a patient spots or bleeds, I would like consultation. I am aware of some patients who had three dilation and curettages before the malignancy was discovered.

KOSE: How often is the result of an endometrial biopsy falsely negative?

KEATING: The best figures I can cite are the two that I mentioned. The Hofmiester studies from Milwaukee go back many years and are large in number.

The Anderson studies from Ann Arbor are very good. I am not sure the figures in a more casual circumstance—such as an average office— would be quite this good, but in both of these studies, the false negative results were no more than 4%. That is an acceptable screening procedure.

MODERATOR: You are speaking of the four quadrant endometrial biopsies?

KEATING: Yes, sir.

MODERATOR: What about the withdrawal bleeding that can be seen as a part of treatment? How would you manage such a patient?

KEATING: By choice, I would reduce her estrogen dosage to below subthreshold level; however, I am not always granted that choice. For example, one of my patients has access to her own source of stilbestrol, which she insists on taking because it relieves her arthritis pain. I don't think it does anything for the arthritis, but it relieves the pain. I finally have weaned her down to 0.2 mg from the 0.5 mg per day she was taking. I have gotten her to cycle the estrogen, but I cannot get her to stop it; and she still bleeds two or three times a year on the dosage of 0.2 mg diethylstibestrol. Therefore, I have had to instruct her to cycle every third month with Provera.® This generally controls the situation, although she bleeds at those times and very rarely at other times.

MODERATOR: Dr. Season, is there any particular arthritis or arthritic condition more benefited by estrogen treatment than any other?

SEASON: I can't think of any.

KOSE: I have read articles that indicate help in rheumatoid arthritis. Other than that, I am not aware of anyone who prescribes estrogen therapy for any specific arthritic condition.

Miscellaneous Problems

KOSE: I have seen half-a-dozen women who are on this type of cycling therapy. When they discontinue it, they get terrible headaches. This happens to women on estrogens alone, and it seems to be more common in those on a progestin agent. How do you try to manage them? Do you try diuretic therapy or do you discontinue the medication again even though they really do need the medicine?

KEATING: First, I would try to sort out the type of headache of which she was complaining. If the headache has characteristics strongly suggesting a vascular origin—one-sided, with visual symptoms, sometimes with an aura then I would insist on a neurologic consultation because of my concern with migraine-like reactions to steroids. There seems to be a definite increased risk of stroke in patients whose reaction to prolonged therapy or withdrawal from steroids results in a migrainous episode. If I am fairly certain that vascular components are minimal, I really am not going to make any major changes in this situation. I will encourage the patient to continue to decrease the dosage to levels that do not permit any further dropping if she's to get relief. But beyond that, I won't take her off the medication automatically.

I see this commonly with the contraceptive pill. With postmenopausal estrogens at these doses, it is rare.

SEASON: If we identify the castrated woman as one who is likely to develop early osteoporosis or advanced osteoporosis and we agree that she should be on a course of estrogens, how long should she remain on the estrogen?

KEATING: Although I don't have an answer for that question, let me see if I can put it in perspective.

Osteoporosis is certainly a high-risk condition. This is especially true if it leads to hip fracture, which I think is the most ominous problem because something like one sixth of hip fractures fail to survive three months after their injury. The risk from osteoporosis is sufficiently high to justify taking the risk of endometrial carcinoma induction. It actually is a greater risk than that by every measure we have, but it is no bargain at all to take that risk for the 75% of women *not* at risk of osteoporosis. This puts us in something of a bind. I need a way to determine which are the 25% at risk of developing osteoporosis.

Since I do not have that, I think I'm harming fewer patients if I take them off estrogen early and don't try to prevent osteoporosis. However, if we can demonstrate that a woman is a high risk for this problem perhaps because of family history, her habitus, or whatever rough guidelines, I would be willing to keep her on estrogen much longer, and possibly for life. In such case, I would also cycle the patient on a progestin.

MODERATOR: Clearly, patients castrated premenopausally are the likely candidates for that 25% group.

SEASON: I agree, but how long should they remain on the estrogen therapy?

MODERATOR: I think the question of when to stop the estrogen therapy is not easy to answer. The patient should continue on the therapy until the vasomotor symptoms are no longer troublesome. Periodically, I advise my patient to stop taking pills for longer than seven days of a

routine off-period. As you follow the geriatric population longitudinally, at some point— 60 years old or maybe 65— the estrogen can be stopped completely. They may have a very mild degree of vasomotor symptoms, and eventually they tolerate it quite well. Very seldom, does the 70-year-old lady need estrogen therapy.

HAMBRICK: Going back to the differential diagnosis, I would like to cite several items that we should consider when a woman comes in with possible menopausal diagnosis. There are seven problems that could be theoretically confused: malignancy, pregnancy, psychologic amenorrhea, pheochromocytoma, thyrotoxicosis, anorexia nervosa, and hypopituitarism.

KOSE: In addition, people ask me about what happens to the T4 (thyroxine) level.

MODERATOR: This is particularly true of those taking birth control pills, but I am not impressed by the effect of the estrogen dose that we are prescribing for the menopausal patients.

KOSE: We see higher doses than what you're talking about, but I think at lower doses that is correct.

KEATING: Do you believe there is any role for the incorporation of androgen therapy with estrogen therapy?

MODERATOR: I feel there is very little place for androgens, and I do not like giving extra androgens when a patient is putting out, relatively speaking in relation to estrogen, more androgen in the postmenopausal period and most of the symptoms are well relieved by estrogens. Because of strong anabolic effects of androgens, it may help the psychological well-being of some. But I occasionally see patients who do have a little more hair growth and side-effects related to androgen therapy. So, I do not use androgens and do not advise their use.

KEATING: I do not prescribe it either.

MODERATOR: There aren't very many companies who manufacture combined preparations of estrogens and androgens. They claim that androgen-contained estrogen preparations tend to cause less breakthrough bleeding, but I am not convinced from a small study I conducted previously. I don't believe androgen adds any more than what we can achieve with pure estrogens, and I do not like to mix the drugs.

Summary

MODERATOR: I think we have covered most of the relevant areas of estrogen therapy. In essence, we all agree that we have to identify the problems and the clear indications. We must recognize there are many current controversial areas. High-risk populations, such as women with premenopausal castration or ovarian failure, should be treated with estrogens regardless of symptoms. As for actual treatment, it has to be individualized; and unfortunately, which estrogen, how much, and how long it should be used still is not clear. These decisions are up to the clinician's judgment when he/she evaluates individual patients.

Thank you for your participation.

Generic and Trade Names of Drugs

Estradiol — Estrace (Mead Johnson)
Conjugated estrogen — Premarin (Ayerst)
Medroxyprogesterone acetate — Provera (Upjohn)
Clomiphene citrate — Clomid (Merrell-National)

Suggested Reading

1. Aitken JM, Hart DM, Lindsay R: Oestrogen replacement therapy for prevention of osteoporosis after oophorectomy. *Br Med J* **3**:513-518, 1973.
2. Anderson DG, Eaton CJ, Galinkin LJ, et al: The cytologic diagnosis of endometrial adenocarcinoma. *Am J Obstet Gynecol* **125**:376-383, 1976.
3. Burch JC, Byrd BF: Results of estrogen treatment in 1,000 hysterectomized women for 14,318 patient years. In: *Consensus on Menopause Research: a summary of international research.* 1st International Congress on the Menopause, La Motte, France, 1976. Edited by van Keep PA, Greenblatt RB, Albert-Fernet M, Baltimore, University Park Press, 1977, pp 164-169.
4. Crile G Jr: Estrogen and the breast. *Clin Obstet Gynecol* **19**: 789-790, 1976.
5. Heaney RP: Estrogens and postmenopausal osteoporosis. *Clin Obstet Gynecol* **19**:791-803, 1976.
6. Hofmeister FJ: Endometrial biopsy: another look. *Am J Obstet Gynecol* **19**:118-773-777, 1974.
7. Kase N: Yes or no on estrogen therapy? A formulation for clinicians. *Clin Obstet Gynecol* **19**:825-836, 1976.
8. Lindsay R, Hart DM, Aitken JM, et al: Long-term prevention of postmenopausal osteoporosis by oestrogen. Evidence for an increased bone mass after delayed onset of oestrogen treatment. *Lancet* **1**(7968):1038-1041, 1976.
9. Lipsett MB: Estrogen use and cancer risk. *JAMA* **237**:1112-1115, 1977.
10. Mack TM, Pike MC, Henderson BE, et al: Estrogens and endometrial cancer in a retirement community. *N Engl J Med* **294**:1262-1267, 1976.
11. Ory HW: Oral contraceptives and breast neoplasia. *Dialogues in Oral Contraceptions* 2, No. 5 (Jan) 1978.
12. Rigg LA, Hermann H, Yen SS: Absorption of estrogens from vaginal creams. *N Engl J Med* **298**:195-197, 1978.
13. Ritterband AB, Jaffe IA, Densen PM, et al: Gonadal function and the development of coronary heart disease. *Circulation* **26**:668, 1962.
14. Ryan KJ: Estrogens and atherosclerosis. *Clin Obstet Gynecol* **19**:805-815, 1976.
15. Sartwell PE: Estrogen replacement therapy and endometrial carcinoma: epidemiologic evidence. *Clin Obstet Gynecol* **19**:817-823, 1976.
16. Silverberg SG, Makowski EL: Endometrial carcinoma in young women taking oral contraceptive agents. *Obstet Gynecol* **46**:503-506, 1975.
17. Smith DC, Ross P, Donovan JT, et al: Association of exogenous estrogen and endometrial carcinoma. *N Engl J Med* **293**:1164-1167, 1975.
18. Weiss NS, Szekely DR, Austin DF: Increasing incidence of endometrial cancer in the United States. *N Engl J Med* **294**:1259-1262, 1976.
19. Wentz AC: Assessment of estrogen and progestin therapy in gynecology and obstetrics. *Clin Obstet Gynecol* **20**:461-482, 1977.
20. Ziel HK, Finkle WD: Increased risk of endometrial carcinoma among users of conjugated estrogens. *N Engl J Med* **293**:1167-1170, 1975.

☆☆☆

TAPE ALONG EDGE

FOLD

FROM_____

PLACE
1st CLASS
POSTAGE
HERE

Ohio State Medical Association
Department of Continuing Medical Education
600 South High Street
Columbus, Ohio 43215

FOLD

ESTROGEN THERAPY

Category I Continuing Medical Education Examination

As an organization accredited for continuing medical education, the OSMA Committee on Scientific Work certifies that this continuing medical education offering meets the criteria for **two (2) credit hours in Category I.** This program also meets the criteria for the Ohio State Medical Board's relicensure program in Category I.

The fee for this continuing medical education offering is $20. The examination will be scored and returned to the physician. This form is a self-mailer — fold and place postage where noted.

Complete the examination by circling or writing the correct answer for each of the 20 questions. Fill in the information requested below, attach a check in the amount of $20 (made payable to **The Ohio State Medical Association**), and mail this examination.

For credit, an examination must be received at OSMA Headquarters on or **before June 1, 1979.**

NAME_____ MEDICAL EDUCATION #_____
(On OSMA Membership Card)

STREET_____

CITY_____ STATE_____ ZIP CODE_____ COUNTY_____

(Turn Page for Examination)

Staple check here

Each of the following questions refers to the article "Estrogen Therapy," which appears on page 691 of this issue of *The Journal*. Circle the correct answer.

1. **If a postmenopausal patient is depressed, it is most prudent to:**
   A. Assume the depression is the result of estrogen deficiency.
   B. Obtain additional history which might bring to light a situational depression.
   C. Start her on a tricyclic antidepressant immediately.
   D. Arrange for immediate psychiatric consultation.

2. **Topical estrogen therapy for atrophic vaginitis:**
   A. Is perfectly safe because little or none of the estrogen is absorbed.
   B. Is usually ineffective and therefore should be abandoned.
   C. Results in higher blood levels than estrogen given orally.
   D. None of the above.

3. **Contraindications to the use of estrogen therapy include all except:**
   A. Severe liver disease.
   B. Pathologic hip fracture.
   C. Cholecystitis/Cholelithiasis.
   D. Severe edema and hypertension.
   E. Unexplained uterine bleeding.

4. **The symptoms of estrogen deficiency include all except:**
   A. Dyspareunia
   B. Hot flushes
   C. Insomnia
   D. Weight gain
   E. Bone loss

5. **Concerning conventional birth control pills, the following statements are correct except:**
   A. Contain estrogen and progestin.
   B. The amount of estrogen contained is a physiologic level and ideal for the use of estrogen replacement.
   C. Increase the risk of coronary heart disease in women over the age of 40 years.
   D. Cigarette smoking tends to further increase the risk of coronary heart disease when they are used by women over the age of 40 years.

6. **Estrogen therapy in relation to liver diseases:**
   A. Is contraindicated with a past history of uncomplicated hepatitis.
   B. May precipitate jaundice in a patient with a past history of jaundice of pregnancy.
   C. May be used with chronic active hepatitis being treated with steroids.
   D. Poses no problems.

7. **The following items concerning Estradiol-17β is true except:**
   A. Biologically most potent.
   B. Absorbed well from the intestinal tract.
   C. Stimulates endometrial growth.
   D. The main source is ovary.

8. **During the perimenopausal periods, the blood levels of gonadotropins are:**
   A. Always normal.
   B. Variable, but never too low.
   C. Parallel to estrogen levels.
   D. Always high.
   E. None of the above.

9. **In the follow-up of menopausal patients, endometrial biopsy is:**
   A. Usually useless because Pap smear is more accurate.
   B. Very informative for evaluating endometrial changes.
   C. As good as D&C in evaluation of the menopausal bleeding.
   D. Not useful because of difficulty to perform.

10. **The major reasons why oral contraceptive pills should not be used in women over the age of 40 years are because of:**
    A. Increase in the risk factor of myocardial infarction.
    B. Increase in the risk factor of endometrial cancer.
    C. Increase in the risk factor of breast cancer.
    D. Increase in the risk factor of epilepsy.
    E. None of the above.

11. **Estrogen replacement therapy may be well indicated in the treatment of postmenopausal osteoporosis for:**
    A. Reversal of the condition.
    B. Complete prevention of fractures.
    C. Palliation of the condition.
    D. It should never be used.
    E. None of the above.

12. **Obese individuals tend to have the following except:**
    A. A lower incidence of osteoporosis.
    B. A higher incidence of endometrial cancer.
    C. More effective clearance of calcium.
    D. A higher conversion rate of androstenedione to estrone.

13. **The following statements concerning endometrial cancer are correct except:**
    A. Retrospective studies show that an increase in estrogen dosage *causes* an increase in risk.
    B. Estrogen has been shown to *cause* endometrial cancer in the human.
    C. Estrogen may be a *contributing factor* in the development of endometrial cancer.
    D. The duration of estrogen therapy appears to be *correlated with the incidence* of endometrial cancer.

14. **Breast carcinoma is associated with the following except:**
    A. That estrogen use by the postmenopausal women increases the risk of breast cancer.
    B. That a patient with positive estrogen receptors in breast carcinoma should respond to hormonal therapy theoretically.
    C. No evidence of oral contraceptives causing breast cancer at the present time.
    D. None of the above.

15. **Concerning estrogen replacement therapy, the following statement is correct:**
    A. Ideally one should start a dosage high enough to relieve the vasomotor symptoms but also to stimulate the endometrial growth.
    B. Ideally, one should start a low dosage that can relieve only the symptoms but not to stimulate the endometrial growth.
    C. Ideally, one should combine it with androgens.
    D. None of the above.

16. **The side-effects of estrogen therapy include all except:**
    A. Breakthrough endometrial bleeding.
    B. Migraine-like headache.
    C. Weight gain.
    D. Breast tenderness.
    E. None of the above.

Circle the correct statement or statements. If none is correct, do not mark any statement.

17.
    A. Estrogen is protective against the development of cardiovascular disease.
    B. Estrogen therapy tends to alter clotting factors in the direction of "superclotting."
    C. Increased risk of coronary occlusion is associated with all estrogen use over the age of 40 years.
    D. There is a reduction in cardiovascular incidents in castrated premenopausal women treated with estrogens.

18. **In postmenopausal osteoporosis:**
    A. Estrogen therapy merely arrests the progress of the condition and stabilizes the skeleton as it is found.
    B. Estrogen reduces calcium loss by increasing calcium resorption in the renal tubules.
    C. Is particularly effective in protecting the younger (surgical) castrate if begun promptly.
    D. Prevents pathological fractures.

19. **Concerning the carcinogenicity of estrogen therapy:**
    A. Estrogens may be considered carcinogenic in the endometrium.
    B. Estrogens may be considered carcinogenic in the breast.
    C. Cancer risks from estrogen therapy are both dose-related and time-related.
    D. Endometrial cytology studies during estrogen therapy are effective screening procedures for detecting neoplastic changes in the endometrium.

20.
    A. There is no need to cycle estrogen therapy according to most authorities.
    B. Estrogen vaginal cream is effective treatment for atrophic vaginal changes, and safe because of its low absorption.
    C. Injections of estrogens are desirable, since they are more rapidly absorbed and more effective than oral estrogens.
    D. The dosage of conjugated estrogens indicated in most of the postmenopausal patients is 0.625 mg per day.



Does it influence your choice of a peripheral/cerebral vasodilator*?

- Vasodilan—compatible with coexisting diseases
- Vasodilan—compatible with concomitant therapy
- Vasodilan—compatible with your total regimen for vascular insufficiency

*Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows

Possibly Effective:

1 For the relief of symptoms associated with cerebral vascular insufficiency

2 In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg and 20 mg

Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral 10 to 20 mg., three or four times daily

Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily Intramuscular administration may be used initially in severe or acute conditions

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses Should not be given immediately postpartum or in the presence of arterial bleeding

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted

Administration of single dose of 10 mg intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses For these reasons single intramuscular doses exceeding 10 mg are not recommended. Repeated administration of 5 to 10 mg intramuscularly at suitable intervals may be employed

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose, Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

U.S. Pat. No. 3,056,836

VASODILAN®

(ISOXSUPRINE HCl)

20-mg tablets

Mead Johnson PHARMACEUTICAL DIVISION

© 1976 MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA 47721 U.S.A. MJL7-4268

This asthmatic isn't worried about his next breath...

he's active he's effectively maintained on

QUIBRON®

Each capsule or tablespoon (15 ml) elixir contains theophylline (anhydrous) 150 mg and glyceryl guaiacolate (guaifenesin) 90 mg. Elixir, alcohol 15%



- theophylline for effective around-the-clock bronchodilator therapy
- 100% free theophylline

Indications: For the symptomatic relief of bronchospastic conditions such as bronchial asthma, chronic bronchitis, and pulmonary emphysema.

Warnings: Do not administer more frequently than every 6 hours, or within 12 hours after rectal dose of any preparation containing theophylline or aminophylline. Do not give other compounds containing xanthine derivatives concurrently.

Precautions: Use with caution in patients with cardiac disease, hepatic or renal impairment. Concurrent administration with certain antibiotics, i.e. clindamycin, erythromycin, troleandomycin, may result in higher serum levels of theophylline. Plasma prothrombin and factor V may increase, but any clinical effect is likely to be small. Metabolites of guaifenesin may contribute to increased urinary 5-hydroxyindoleacetic acid readings, when determined with nitrosonaphthol reagent. Safe use in pregnancy has not been established. Use in case of pregnancy only when clearly needed.

Adverse Reactions: Theophylline may exert some stimulating effect on the central nervous system. Its administration may cause local irritation of the gastric mucosa, with possible gastric discomfort, nausea, and vomiting. The frequency of adverse reactions is related to the serum theophylline level and is not usually a problem at serum theophylline levels below 20 μg/ml.

How Supplied: Capsules in bottles of 100 and 1000 and unit-dose packs of 100; Elixir in bottles of 1 pint and 1 gallon.

See package insert for complete prescribing information.

Mead Johnson PHARMACEUTICAL DIVISION

©1978 Mead Johnson & Company • Evansville, Indiana 47721 U.S.A. MJL 8-4294R

Physical Treatment of Pain and Weakness Following Radical Neck Dissection

Ernest W. Johnson, M.D.
John N. Aseff, M.D.
William Saunders, M.D.

A review of a home physical treatment program following radical neck dissection is presented. All of the 16 patients were having pain and were unable to fully use the involved extremity. They were benefited significantly by this treatment program.

WEAKNESS AND DEFORMITY of the shoulder, often painful, are well-documented difficulties that follow classical radical neck dissection with excision of the sternocleidomastoid muscle and division of the spinal accessory nerve supplying the trapezius muscle. However, the superficial course of the spinal accessory nerve in the posterior cervical triangle also makes the nerve particularly susceptible to injury during even minor surgical procedures in this area,[1-3] to the extent that this pattern even has been called the "lymph node biopsy syndrome."[4] To avoid these postoperative difficulties, some surgeons have advocated grafting between the cut ends of the spinal accessory nerve using the greater auricular nerve. Although not common, this procedure reportedly affords adequate neural supply to the trapezius muscle in most instances.[5] Others have performed various types of modified neck dissection in which both the sternocleidomastoid muscle and the nerve supply to the trapezius are spared. However, most surgeons still prefer the classical operation to the various modified or conservative procedures for the complete removal of the patient's malignancy. Finally, some surgeons have recommended neurolysis procedures and fascial stabilization with tendon transfers for treatment following section of the spinal accessory nerve during minor surgical procedures in the posterior cervical triangle.[4]

Dr. Johnson, Columbus, Professor and Chairman, Department of Physical Medicine, The Ohio State University College of Medicine.
Dr. Aseff, Cincinnati, Assistant Professor, Department of Physical Medicine, University of Cincinnati College of Medicine.
Dr. Saunders, Columbus, Chairman, Department of Otolaryngology, The Ohio State University College of Medicine.
Submitted May 17, 1978.

Kinesiology

Sectioning of the XI cranial nerve compromises the function of two muscles, the sternocleidomastoid and the trapezius. The trapezius is an important stabilizer of the scapula; it has three parts - upper, middle, and lower - and is a large muscle, extending inferiorly farther than is commonly realized. It resembles a fan, attaching to the vertebrae at one end and to the scapular spine at the other. Its function includes hugging the scapula tightly to the posterior thoracic cage during movements of the arm, rotating the scapula upward and downward, and retracting it. Participating muscles that compensate for loss of the trapezius are the levator scapulae and the rhomboids.

Innervation of the trapezius muscle still is a matter of dispute. Most authors agree that the trapezius muscle is supplied by the spinal accessory (XI cranial nerve) and by fibers from cervical roots.[6] However, opinions regarding the distribution of these two components are very contradictory. Seddon (1972) stated that the fibers coming from cervical roots are purely sensory. Bodectel (1963), Haymaker and Woodhall (1953), and Piersol (1911) concluded that the trapezius is supplied only by cervical fibers in at least some cases. Rosenstein (1935) has mentioned that only the ascending and horizontal parts of the trapezius muscle are innervated by the accessory nerve, while the descending upper part has a purely cervical supply.[6] On the other hand, Cihak noted during the dissection of 50 embryos and fetuses of various vertex-coccyx lengths that the branches of cervical nerves, together with the accessory nerve, create a plexus ("trapezoid plexus") which divides into proximal and distal segments, which then innervates the trapezius muscle, with the accessory nerve with cervical nerves being variable. Cihak further stated that a constant, independent

innervation of any part of the muscle from only cervical nerves could not be demonstrated.[7] Fahrer, et al (1974), in their electrophysiologic study, also concluded that the proportion between accessory nerve and cervical root supply shows great individual variation. Their data further indicated, however, that all three parts of the trapezius muscle are normally supplied by the accessory nerve, with no evidence suggesting that the trapezius muscle can be supplied only by cervical fibers.[6]

The usual test for trapezius function (having the patient shrug his shoulder against resistance) tests the upper trapezius chiefly. A better, or an additional test, is to have the patient hold both arms in full abduction above his head while the examiner pulls each arm downward and laterally against resistance. The weakened middle and lower trapezius muscles are demonstrated as one arm is brought down significantly more easily than the other. More effective testing for the middle and lower segments is done with the patient lying prone, arms outstretched laterally, and thumbs pointed dorsally in the "hitchhiking" position. Then having the patient raise his arms in the direction of the upward extended thumbs brings these muscles into prominence.

The major antagonist of the trapezius may be considered to be the serratus anterior muscle, which moves the scapula forward and downward when the trapezius is paralyzed. In paralysis, the vertebral border of the scapula becomes flared, particularly inferiorly and laterally. This flaring is accentuated when the arm is abducted from the side against resistance. Furthermore, since the scapula must be stabilized and synergistically moved in concert with the humerous about the scapulohumeral joint, abduction of the shoulder is apt to be limited. Ewing and Martin,[8] reporting on 100 patients with radical neck dissections associated with malignancies arising from a variety of sites, found that shoulder abduction is most frequently and seriously impaired. Other authors report inability to abduct above 90 degrees [9,10] or report widely varying abilities at abduction which were attributed to incomplete "denervation" of the trapezius.[11-14] Patients with marked loss of shoulder abduction, 70 degrees or less, characteristically try to compensate by contralateral trunk flexion. Even though the trapezius is paralyzed, the shoulder forward flexors may elevate the arm 180 degrees or less, since the serratus anterior can stabilize the scapula with the arm in the forward flexed position. Thus it may appear that the patient is abducting the arm while, in reality, he is using flexors to raise the arm above the head. Furthermore, since rotation of the shoulder joint must accompany abduction, the extremes of external rotation are often lost because of pain and disuse. Pain associated with the surgery, at least in the early postoperative period, may limit extremes of shoulder motion. The scapulohumeral joint tends to lose motion and, in some cases, develops a condition best described as periarthritis or adhesive capsulitis of the shoulder. After operation, the scapulohumeral complex characteristically is forward and downward.

Functional limitations after neck dissection are imposed by (1) painful, limited motion of the scapulohumeral joint (periarthritis); and (2) inability to fully abduct the shoulder because of loss of scapular stability (Fig. 1).

Cosmetic considerations include the forward and downward displacement of the shoulder complex (Fig. 2). Also, loss of sternocleidomastoid muscle produces abnormal contour at the junction of the neck and shoulder as well as a flatness of one side of the neck. Atrophy of the trapezius muscle is particularly evident in its upper portion.

Shoulder pain is relatively common following division of the spinal accessory nerve.[8, 10-12, 14-16] It was the primary reason for referral of the 16 consecutive patients to our department of physical medicine for outpatient management. The pain usually is described as "dull and aching" and "nagging," is increased by exertion of neck or shoulder movement, and usually is poorly localized about the posterior or posteriolateral aspects of the shoulder or neck base. Presumably, the pain is due to stretching of the chief scapular retractor (rhomboids) and elevator (levator scapulae) as a consequence of the now unbalanced pull of the serratus anterior muscle. A secondary periarthritis of the scapulohumeral joint often may occur, especially in the few weeks after surgery. Less commonly, an osteoarthritis of the sternoclavicular joint on the paralyzed side may contribute to the pain syndrome. This results from long-standing stress imposed by the forward and downward position of the scapulohumeral complex.[8,10,12,13,15-17] Neuroma of the sectioned nerves with entrapment in scar tissue also has been described as a source of postoperative pain.[14]

Patients and Program

The 16 patients in our sample ranged in age from 45 to 76 years. Nine men and seven women had six right-sided procedures, five had left-sided ones, and five were bilateral procedures. Electromyograms (EMGs) for ten



Fig. 1. Limited shoulder abduction after paralysis of XI cranial nerve.



Fig. 2. Forward and downward position of shoulder complex after XI cranial nerve paralysis.

patients demonstrated involvement of all three portions of the trapezius muscle on the involved side. The patients were followed from the initial referral at three to four weeks after surgery for as long as two years following surgery.

The objectives of our outpatient program included: (1) relief of pain; (2) strengthening the muscles that compensate for the trapezius; (3) stretching the serratus anterior; and (4) maintaining or increasing the range of motion of the scapulohumeral joint.

Treatment

Our physical treatment program consisted of: (1) infrared, using a luminous 250-watt lamp at home for pain relief; (2) strengthening the scapular retractors and elevators, using modified progressive resistance technique, first ten repetitive exercises at maximum effort (10 repetitive maximum), then ¾ 10 RM, and finally ½ 10 RM; (active range-of-motion exercises by the patient's spouse to increase scapulohumeral joint motion; and (4) active stretch of the shortened scapular protractors and depressors (serratur anterior). The patient is instructed in two or three sessions by the physical therapist, then checked every three to four weeks to insure progress. Color photographs (35-mm) are useful to demonstrate cosmetic improvement, especially the position of the shoulder complex.

Our physical treatment resulted in significant or total relief of pain in all 16 patients, and improvement in posture in 15 patients. Functional improvement of the arm occurred as shoulder motion increased and the compensatory muscles were strengthened (Fig. 3). On occasion of their final visits, 12 of the 16 patients stated voluntarily that they sensed a feeling of improvement and well-being.

Summary

Sixteen patients were instructed in a home physical treatment program following radical neck dissection. Major residuals were pain and inability to fully use the involved extremity. All of these patients benefited significantly from the strengthening of the rhomboids and levator scapulae (remaining scapular retractors and elevators) and stretching of the over-active serratus anterior.

References

1. Woodhall B: Trapezius paralysis following minor surgical procedures in posterior cervical triangle: results following cranial nerve suture. *Ann Surg* **136**:375-380, 1952.
2. Hubault A, Fages A, Kahn MF, et al: Une pseudo-périarthrite de l'epaule: la paralysie du trapeze par lésion chirurgicale du nerf spinal. *Sem Hop Paris* **48**:3029-3037, 1972.
3. Norden A: Peripheral injuries to spinal accessory nerve. *Acta Chir Scand* **94**:515-532, 1946.
4. Dunn AW: Trapezius paralysis after minor surgical procedures in the posterior cervical triangle. *South Med J* **67**:312-315, 1974.
5. Harris HH, Dickey JR: Nerve grafting to restore function of the trapezius muscle after radical neck dissection: a preliminary report. *Ann Otol Rhinol Laryngol* **74**:800-806, 1965.
6. Fahrer H, Ludin HP, Mumenthaler M, et al: The innervation of the trapezius muscle: an electrophysiological study. *J Neurol* **207**:183-188, 1974.
7. Cihak R: Musculus trapezius and the changes of its forma-

(continued on next page)



Fig. 3. Improved shoulder abduction after strengthening through exercise program.

tion in human ontogenesis. *Acta Univ Carol Med (Praha)* 20:45-66, 1974.
8. Ewing MR, Martin H: Disability following "radical neck dissection": assessment based on postoperative evaluation of 100 patients. *Cancer* 5:873-883, 1952.
9. Skolnik EM: Therapy of laryngeal cancer. *Arch Otolaryngol* 83:92-103, 1966.
10. Mead S: Posterior triangle operations and trapezius paralysis. *Arch Surg* 64:752-755, 1952.
11. Hoaglung FT, Duthie RB: Surgical reconstruction for shoulder pain after radical neck dissection. *Amer J Surg* 112:522-526, 1966.
12. Szunyogh B: Shoulder disability following radical neck dissection. *Amer Surg* 25(3):194-198, 1959.
13. Dietz JH Jr: Rehabilitation of the cancer patient. *Med Clin North Amer* 53:607-624, 1969.
14. King PS, Lewis FR, Weddle JL, et al: Effect of radical neck dissection on total rehabilitation of the laryngectomee. *Amer J Phys Med* 52:1-17, 1973.
15. Skolnik EM, Tenta LT, Wineinger DM, et al: Preservation of the eleventh cranial nerve in neck dissection. *Laryngoscope* 77:1304-1314, 1967.
16. Nahum AM, Mullally W, Marmor L: A syndrome resulting from radical neck dissection. *Arch Otolaryngol* 74:424-428, 1961.
17. Simpson SA, Gordon SS, Jorgens J, et al: Roentgen changes following radical neck dissection. *Radiology* 67(5):704-713, 1956. ☆☆☆



WINDSOR HOSPITAL
A NONPROFIT CORPORATION
— ESTABLISHED 1898 —
Chagrin Falls, Ohio
247 - 5300
A hospital for the treatment of Psychiatric Disorders
High on a Hill-Top, Overlooking Beautiful Chagrin River Valley.
Accredited by Joint Commission on Accreditation of Hospitals.
Booklet available on request.
FRIEDRICH A. LINGL, M.D. Medical Director
GUY H. WILLIAMS, JR., M.D. Medical Director Emeritus
HERBERT A. SIHLER Jr. President
MEMBER: American Hospital Association—National Association of Private Psychiatric Hospitals

NUTRITION AND THE HOSPITALIZED PATIENT

John W. Broviac, M.D.
E. W. Sparrow Hospital
Lansing, Michigan
Asst. Prof. of Medicine
Michigan State University
East Lansing, Michigan

Alexander E. Nehme, M.D.
Educational Chief of Surgery
Hurley Medical Center
Flint, Michigan
Asst. Prof. of Surgery
Michigan State University
East Lansing, Michigan

Mitchell V. Kaminski, Jr., M.D.
Clinical Prof. of Surgery
University of Health Sciences
Chicago Medical School
Director
Midwest Nutrition Education and Research Foundation
St. Mary of Nazareth Hospital Center
Chicago, Illinois

Anne L. Winborn, R.D.
Research Dietitian
Metabolic Support Service
St. Mary of Nazareth Hospital Center

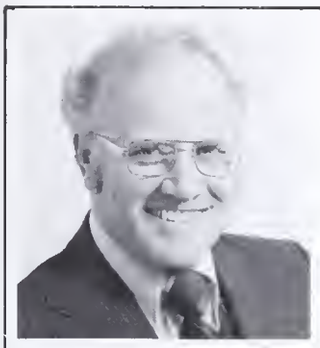
NUTRITION SUPPORT TEAM
Judene Bartley, M.P.H.
Charlotte Gibson, R.D.
Sherry Goodfellow, M.S., R.D.
Connie Hagelshaw, M.S., R.D.
Walter Hickey, R.Ph.
Hope McCracken, R.Ph.
Denise Rumsey, R.D.
Hurley Medical Center
Flint, Michigan

Saturday, December 2, 1978 – 9:00 a.m. - 3:45 p.m.
Approved for Six Category I hours

HURLEY MEDICAL CENTER

For further information call or write: **Richard D. Garlick**
Director of Continuing Medical Education – **Hurley Medical Center**
Sixth Avenue and Begole Street – Flint, Michigan 48502 (313) 766-0142

Sponsored By: **Hurley Medical Center Nutrition Support Team, Department of Continuing Medical Education** and **Norwich-Eaton Pharmaceuticals**



J. HARRY MOSHER, CLU
VICE PRESIDENT

CONSULT WITH . . .
The Professionals!

These T&S representatives provide professional service throughout the state to members of The Ohio State Medical Association.

Feel free to call the Turner and Shepard office nearest you for insurance counseling, advice, or information on the Association-sponsored coverages which we administer.

- **Group Term Life Plan**
- **Disability Income Protection Plan**
  (co-sponsored with many local medical societies)



JIM LEWIS
COLUMBUS



JOE VOLZ
CINCINNATI

TURNER & SHEPARD, inc.

AFFILIATED WITH ALEXANDER & ALEXANDER, INC.

Columbus, Ohio 43215	17 South High Street	Phone (614) 228-6115
Akron, Ohio 44313	3090 West Market Street	Phone (216) 434-5000
Cincinnati, Ohio 45241	4015 Executive Park Drive	Phone (513) 563-4220
Cleveland, Ohio 44134	1440 Snow Road	Phone (216) 741-4466
Toledo, Ohio 43606	3450 West Central Avenue	Phone (419) 535-0616



SHERRY RAMSEY
COLUMBUS



MAURY JONES, CLU
CINCINNATI



ED GIACO
CLEVELAND



MIKE SEKERAK
CLEVELAND



BOB ROEHL
TOLEDO



CLIFF MOSHER
AKRON-CLEVELAND

A Difference in Theophylline Therapy

micro-pulverized

BRONKODYL® Capsules

brand of theophylline, USP (anhydrous)



- **Achieves blood levels rapidly**
- **With minimal gastric irritation***

*Please see complete prescribing information, a summary of which follows.

DESCRIPTION:
Each green and white hard gelatin capsule contains theophylline USP anhydrous, 200 mg., in a micro-pulverized form. Each brown and white hard gelatin capsule contains 100 mg. The elixir contains 80 mg. theophylline per 15 ml. in a 20% alcohol elixir (approximately 20 calories, 0.9 gm carbohydrate per tablespoonful).

ACTION: Theophylline is a methylxanthine which relaxes the smooth musculature of the bronchioles through its inhibition of the conversion of cyclic adenosine monophosphate to adenosine monophosphate by phosphodiesterase. It also has diuretic, cardiotonic, and CNS stimulant effects.

INDICATIONS: Bronkodyl is indicated for symptomatic relaxation of bronchiolar spasm in the chronic obstructive bronchopulmonary diseases; e.g., bronchial asthma, chronic bronchitis and pulmonary emphysema.

CONTRAINDICATIONS: Bronkodyl is contraindicated in persons known to have had serious idiosyncratic responses to theophylline, its salts, or the other methylxanthines, theobromine, or caffeine and may be contraindicated in peptic ulcer.

WARNINGS: All methylxanthines should be used with caution in children and in others who are currently taking bronchodilator products, especially in rectal dosage form, which may contain theophylline or related drugs.

USAGE IN PREGNANCY: Although theophylline has been used for many years, with no evidence of adverse fetal effect or teratogenicity, its safety in pregnancy has not been established. Therefore use of Bronkodyl during lactation or in women of childbearing potential requires that possible benefits of the drug be weighed against possible hazards to fetus or child.

PRECAUTIONS: Bronkodyl should be used with caution in patients with cardiac or circulatory disease.

ADVERSE REACTIONS: Gastrointestinal: Epigastric distress, nausea, vomiting. Cardiovascular: palpitations. CNS: Insomnia, restlessness, irritability, convulsion.

DOSAGE AND ADMINISTRATION: Adults: Usual dosage of Bronkodyl is 200 mg. every 6 hours (four doses in each 24 hours). This dosage may be adjusted to reflect individual clinical response as an indication of slow or rapid metabolism of the drug. If adverse reactions are encountered, each dose may be reduced, or the interval between doses may be lengthened, or both. If clinical response is not satisfactory, indicating possible rapid inactivation of the drug, dosage may be gradually increased to achieve the desired response. In some instances of either too slow or too rapid metabolism, plasma levels of theophylline should be determined and dosage adjusted accordingly to achieve levels above 10 mcg/ml, but not to exceed 20 mcg/ml.

Dosage in Children: Usual dosage should be based on administration of 10 mg per kg per 24 hours, divided in 4 doses per day, given every 6 hours. As this may not be possible with use of the capsules, Bronkodyl elixir may be used. Theophylline saliva levels (approximately 60% of simultaneous blood levels), may facilitate dosage adjustments, especially in children, to obtain appropriate response.

HOW SUPPLIED:
Bronkodyl 100 mg., brown and white capsules in 100's, Code #1831.
Bronkodyl 200 mg., green and white capsules in 100's, Code #1833.
Bronkodyl Elixir, 80 mg. per 15 ml, in pints, Code #1835.

BREON LABORATORIES INC.
90 Park Avenue, New York, N.Y. 10016

Melanoma and Its Immunotherapy

Jeanne A. Petrek, M.D.
John P. Minton, M.D., Ph.D.

Melanoma almost always can be discovered visually, which should aid in its early detection. However, 60% of those patients with a diagnosis of melanoma will be dead of the disease within five years after it is diagnosed.

Perhaps more than any other malignant disease, melanoma has immunologic properties that can be demonstrated and evaluated. This report discusses the historic, pathologic, clinical, and biochemical reasons behind the response of melanoma to immunotherapy. The principles delineated by the large amount of attention focused on a relatively uncommon disease should be applicable to all types of carcinoma.

ALTHOUGH MELANOMA IS UNCOMMON, its incidence has been rising rapidly and the reasons are unknown. It constitutes 3% of all carcinomas and affects about 9,000 Americans each year. The diagnosis of melanoma is easily made by pathologic examination. Any suspicious, or any nonsuspicious mole which changes in any way should be biopsied or excised. Any mole which is shaved or excised should always be examined pathologically.

The immunologic properties leading to clinical control of the disease can be demonstrated and evaluated more easily in melanoma than in other types of carcinoma. The immunologic principles delineated by this research on melanoma should be applicable to other cancers.

Immunotherapy is the newest modality available for the treatment of malignant diseases. It joins surgery, radiotherapy, chemotherapy, and endocrinotherapy as tools in the effort to eradicate small amounts of the disease. This report discusses the various types of immunotherapy in melanoma, which are the basis of extensive application in treatment trials for other malignant diseases.

Hippocrates is credited with the first recorded visual observation and description of malignant melanoma. The term "melanoma" was first used in a treatise on the disease by Carswell in the early part of the 19th century. For at least the past 100 years, it has been documented that "the fatal black tumor" can regress spontaneously,[1] and indeed this is more frequent than in any other type of malignancy. Primary tumors have a reported regression rate of 7% to 10% although it is extremely unusual for a metastatic lesion to disappear. The usual pattern, as observed by Sutton,[2] is a "halo" of depigmentation around the "mole" followed by disappearance and replacement by a shallow scar. Spontaneous regression is thought to have an immunologic basis and to show the surveillance of the body's immune system. The histopathologic changes in Sutton's "halo" consist of small lymphocytes invading the entire area around the nevus and extending between the melanocytes. The melanocytes or nevus cells may be completely destroyed with pigments released and carried away by macrophages.

The unpredictable clinical course of melanoma can include patients with complete spontaneous regression as well as patients with decades between removal of the primary lesion and appearance of metastases with rapid spread. This variable patient response to the same disease indicates that such systemic factors as immunologic interaction must affect the otherwise uniform growth and survival of tumor cells.

Stuhmiller and Seigler[3] have shown that melanoma cells rapidly release large amounts of tumor-associated antigen and that the release and regeneration time in vivo is approximately four hours. They have found at least two separate antigens not found on normal cells. Shiku[4] had demonstrated that the melanoma cells from many different patients have some antigens in common. Each patient, however, also has antigens from his melanoma cells not present in other patients. Gupta and Morton[5] have documented specific antitumor antibodies bound to the melanoma tissues in the human body.

There appears to be a correlation between clinical status of the melanoma patient and incidence of anti-melanoma antibodies in his serum. Patients with localized melanoma were more likely to have antibody in their sera than those patients with disseminated disease in whom tumor bulk and its effect on nutrition overwhelmed the immune system.[6,7]

Dr. Petrek, New York City, Surgical Oncology Fellow, Memorial Sloan Kettering Institute, New York, N.Y.
Dr. Minton, Columbus, Professor of Surgery, The Ohio State University College of Medicine.
Submitted June 15, 1978.

Melanomas frequently are infiltrated or surrounded by a variety of other cells, including macrophages, eosinphils, lymphocytes, histocytes, and/or plasma cells.[8] Moreover, the macrophage content of the early melanoma is greater than that of metastases.[9]

Initial Immunotherapy — Bacille Calmette-Guerin (BCG) Injections Into the Metastatic Nodule

BCG is the attenuated tubercle bacillus *Mycobacterium bovis* and has been used in the prophylaxis of tuberculosis for more than 50 years. More recently, it was noted to increase host resistance to infections by other bacteria, as well as to heighten host defense to a variety of experimental tumors. It has no direct antitumor activity. Indeed, BCG has an effect only if the patient demonstrates immune competence with delayed hypersensitivity by becoming tuberculin positive. BCG contains some of the same antigens as melanoma which may account for some of its antitumor effects. BCG decreases the natural development of many different types of spontaneous neoplasms in mice.[10]

Morton, et al[11] treated patients by direct injection of BCG into metastatic cutaneous nodules of melanoma, hoping to stimulate immunologically based cells in the immediate environment. Regression of tumor nodules occurred only in patients who were immunologically competent. The criteria for competence were the ability to display hypersensitivity response to dinitrochlorobenzene (DNCB) and a positive tuberculin reaction after BCG injection. Approximately 90% of melanoma nodules regressed following intranodular BCG injection.

Sequential biopsies of regressing tumor nodules following BCG innoculation revealed granulomatous formations of lymphocytes, monocytes, and fibroblasts surrounding and infiltrating the melanoma cells. This signified the activation of immune cells.

Even more importantly, nodules distant from the BCG innoculation also regressed in approximately 20% of patients who were immunologically competent. This same group had systemic disease remission of one to seven years. Response to immunotherapy was associated with a rising titer of antimelanoma antibodies.

Although the patients in Morton's study had skin and subcutaneous metastases mainly, it is clear that they also had subclinical, undetectable disease at metastatic sites in other organs. In that group of patients with a long disease-free interval, BCG immunotherapy appears to have controlled or eliminated small metastatic deposits at visceral sites. Therefore, BCG immunotherapy was next employed in the adjuvant treatment of those melanoma patients who had all their known disease resected, but who remained at high risk for recurrence.

BCG and the Theory of Adjuvant Immunotherapy

Animal studies have proved that host defenses are capable of destroying small numbers of tumor cells on the order of one to ten million, but not 100 million or more.[12] Since a neoplasm only 1 cm in diameter contains approximately a billion tumor cells, by the time most tumors are clinically detectable, they have already outgrown the patient's immune defenses. Patients who have only small foci of tumor cells remaining after major surgical, radiotherapeutic, or chemotherapeutic ablation are the ones most likely to benefit from immunotherapy. These patients also should be more responsive because general immune competence is greatest when the disease is localized. In addition, the specificity of immune response may enable immunotherapy to control tumor cells unreachable by other systemic modalities.

Patients with positive lymph nodes on lymph node dissection and with no clinical or radiologic evidence of other metastatic disease possess a 60% to 80% chance of recurrent metastatic melanoma.[13]

Sixty percent of those patients in this high-risk group who received BCG by scarification had no evidence of disease two years later. On the other hand, only 20% of a concurrent (but not randomized) control group had no evidence of disease after two years. Randomized trials in several national protocols are currently underway to evaluate BCG in the adjuvant setting.

BCG Treatment in Systemic Metastatic Disease

Gutterman, et al also used BCG in nonrandomized patients with widely metastatic melanoma in combination with dimethyl triazeno imidazole carboxamide (DTIC), the chief chemotherapeutic agent used in melanoma.[14] This nonrandomized study appears to show an additive synergistic effect of BCG with DTIC or DTIC alone. However, critics have questioned whether immunostimulation could be detrimental to the patient through increase of blocking factors, such as antibody or tumor antigen-antibody complexes which "cover" the antigenic sites on the tumor cells and thereby protect the tumor cells from the immune lymphocytes. Blocking factors favor tumor growth, a process termed "enhancement." Enhancement regularly occurs with immunostimulation in metastatic animal systems.

Investigators who employ BCG systemically (as opposed to intralesionally) in patients with metastatic melanoma believe that BCG may activate the reticuloendothelial system to remove antigen-antibody blocking complexes.[15] Removal of blocking factors and the large amounts of circulating antigen-antibody complexes may permit the natural functioning of the cell-mediated and humoral immunity systems.

These investigators are faced with complications due to the lack of precise information about optimum routes for BCG administration (intradermal, intravenous, scarification, intranodular, oral), schedules, relative efficacy of the various strains, and the importance of the ratio of living to dead organisms in the BCG product.

BCG can produce ulcers at the sites of injection, systemic BCG infections, granulomatous hepatitis, and infrequent anaphylactic reactions. Most patients who receive it experience transitory malaise, fever, and chills.

Active Immunotherapy with Other Agents

BCG is the best known example of active immunotherapy which endeavors to stimulate endogenous antitumor immunity. It augments the immune response nonspecifically, probably by stimulating the reticuloendothelial system.[16] The rationale for these agents derives from the observations of Coley[17] and others that mixed bacterial toxins and fractions of the tubercle bacillus have the ability to stimulate host resistance nonspecifically to most viral, fungal, and bacterial agents as well as to tumor antigens.

Corynebacterium parvum is a gram-positive anaerobic organism with a mechanism of action similar to BCG.[18] As a nonspecific vaccine, it has the advantage of producing its effects as a killed preparation.

Levamisole hydrochloride is a synthetic agent used extensively outside the United States to treat intestinal infections. It can restore patients' depressed immune status to normal, however, it seems to have little or no effect on the intact normal immune system.[19] It has the advantage of usage in an oral form with few side-effects.

Patients have been immunized specifically with vaccines prepared from their own melanoma or from other patients' melanoma in a simple technique like that of smallpox vaccination.[20] The vaccines have been prepared by enzyme degradation or x-ray irradiation of the tumor cells partly in the effort to break apart the cell wall with the antigens contained there.[21] It is hoped that the antigenicity, and thereby the immune response, will be improved by presenting the antigen to the immune cells in a different way. Patients with active melanoma have been cross-immunized.[22]

Passive Immunotherapy

Passive immunotherapy entails the administration of antitumor serum, cells, or factors manufactured in animals or other humans. There are some reports of remissions of melanoma in patients who have had transfusions of blood or serum obtained from patients who had regressions of their melanomas in the past.[23] Investigators have infused informational subcellular material, such as "transfer factor" from regressed cases or nonmelanomatous family members,[24] or "immune" RNA which was extracted from the lymphocytes of patients who had recovered from melanoma or obtained from the lymphocytes of immunized experimental animals.[25] Such materials are not antibodies or antigens in themselves. They can program the lymphocytes of the recipient against the tumor. One can also administer the patient's own lymphocytes back to him or her after they have been sensitized to melanoma antigen tissue culture.[26]

Summary

Immunologic behavior has been demonstrated and evaluated better in melanoma than in any other type of carcinoma. The history, pathology, biochemistry, and clinical course, which often can be followed visually, are peculiar to melanoma. These peculiarities make the response to immunotherapy easier to test; they have provided groundwork for principles of immunotherapy that are currently under treatment trials in other malignant diseases.

Immunotherapy may be particularly helpful in stimulating host defenses to eradicate small amounts of carcinoma in micrometastases left behind by surgery or to mount a more effective response to large systemic metastases.

Active immunotherapy with immune stimulants such as BCG, levamisole, and vaccines made from melanoma cells have been investigated for treatment of melanoma in the adjuvant setting, as well as in gross systemic disease. Passive immunotherapy for melanoma includes antitumor serum, cells, or factors such as ribonucleic acid ("immune RNA") which are synthesized in animals or other humans and then injected into the patient.

Almost all of the trials mentioned herein have been performed in the last ten years on relatively small numbers of patients. Some fortunate patients have attained noteworthy clinical benefit, others have not. Much remains to be accomplished in defining the role of immunotherapy in the treatment of melanoma. With the groundwork laid, information leading to the more scientific use of immunotherapy will be obtained from properly designed prospective trials using randomized control groups. Melanoma is an ideal disease for attempting to maximize benefit from immunotherapy.

For information about the excellent existing trials, contact Dorothy Windhorse, M.D., Coordinator, International Registry of Tumor Immunotherapy, National Institutes of Health, Building 10, Room 4B15, Bethesda, Md., 20014. Information also is available from Dr. Minton at The Ohio State University Hospitals, 410 West Tenth Ave., Columbus, Ohio 43210.

References

1. Everson TC: Spontaneous regression of cancer. *Ann NY Acad Sci* **114**:721-735, 1964.
2. Sutton RL: An unusual variety of vitiligo (leucoderma acquisitum centrifugum). *J Cuton Dis Syph* **34**:797-800, 1916.
3. Stuhmiller GM, Seigler HF: Enzymatic susceptibility and spontaneous release of human melanoma tumor-associated antigens. *J Natl Cancer Inst* **58**:215-221, 1977.
4. Shiku H, Takahashi T, Oettgen HF, et al: Cell surface antigens of human malignant melanoma. *J Exp Med* **144**: 873-881, 1976.
5. Gupta RK, Morton DL: Suggestive evidence for *in vivo* binding of specific antihumor antibodies of human melanomas. *Cancer Res* **35**:58-62, 1975.
6. Laucius JF, Bodurtha AJ, Mastrangelo MJ, et al: Bacillus Calmette-Guerin in the treatment of neoplastic disease. *J Reticuloendothel Soc* **16**:347-373, 1974.
7. Lewis MG, Ikonopisov RL, Nairn RC, et al: Tumor-specific antibodies in human malignant melanoma and their relationship to the extent of the disease. *Brit Med J* **3**:547-552, 1969.
8. Cochran AJ: Histology and prognosis in malignant melanoma. *J Pathol* **97**:459-468, 1969.
9. Gauci CL, Alexander P. The macrophage content of some human tumours. *Cancer Lett* **1**:29-32, 1975.

10. Minden P, McClatchy JK, Wainberg M, et al: Shared antigens between mycobacterium bovis (BCG) and neoplastic cells. *J Natl Cancer Inst* **53**:1325-1331, 1974.
11. Morton DL, Eilber FR, Holmes EC, et al: BCG immunotherapy of malignant melanoma: summary of a seven-year experience. *Ann Surg* **180**:635-643, 1974.
12. Harris J: Tumor immunology, in *Clinical Oncology* (Horton J, Hill GJ, eds), Philadelphia, W B Saunders, 1977, pp 192-223.
13. DeVita VT Jr, Fisher RI: Natural history of malignant melanoma as related to therapy. *Cancer Treat Rep* **60**: 153-157, 1976.
14. Gutterman JU, Mavligit G, Gottlieb JA, et al: Chemoimmunotherapy of disseminated malignant melanoma with dimethyl triazeno imidazole carboxamide and Bacillus Calmette-Guerin. *N Engl J Med* **291**:592-597, 1974.
15. Baldwin RW, Pimm MV: BCG immunotherapy of pulmonary growths from intravenously transferred rat tumour cells. *Br J Cancer* **27**:48-54, 1973.
16. Bast RC, Zbar B, Borsos T, et al: BCG and cancer. *N Engl J Med* **290**:1413-1420 and 1458-1469, 1974.
17. Coley WB: A report of recent cases of inoperable sarcoma successfully treated with mixed toxins of erysipelas and Bacillus prodigiosus. *Surg Gynecol Obstet* **13**:174-190, 1911.
18. Reed RC, Gutterman JU, Mavligit GM, et al: Corynebacterium parvum: preliminary report of a phase I clinical and immunological study in cancer patients, in *Corynebacterium Parvum: Applications in Experimental and Clinical Oncology* (Halpern B, ed), New York, Plenum, 1975, pp 349-366.
19. Amery WK: The reticuloendothelial system, cancer and cancer immunotherapy. *J Reticuloendothel Soc* **21**:417-421, 1977.
20. Currie GA, McElwain TJ: Active immunotherapy as an adjunct to chemotherapy in the treatment of disseminated malignant melanoma: a pilot study. *Br J Cancer* **31**: 143-156, 1975.
21. Simmons RL, Rios A: Combined use of BCG and neuraminidase in experimental tumor immunotherapy. *Surg Forum* **22**:99-101, 1971.
22. Willoughby H, Latour JP, Tabah EJ, et al: Cross-implantation of tumor tissue and cross-transfusion in patients with advanced cancer. *Am J Obstet Gynecol* **108**:889-893, 1970.
23. Everson TC, Cole WH: *Spontaneous Regression of Cancer*. Philadelphia, Saunders, 1966, pp 1-560.
24. Spitler LE, Wybran J, Fudenberg HH, et al: Transfer factor therapy of malignant melanoma. *Clin Res* **21**:221, 1973.
25. Pilch YH, Fritze D, Kern DH: Immune RNA in the immunotherapy of cancer. *Med Clin North Am* **60**:567-583, 1976.
26. Treves AJ, Cohen IR, Feldman M: Immunotherapy of lethal metastases by lymphocytes sensitized against tumor cells in vitro. *J Natl Cancer Inst* **54**:777-780, 1975.
27. Knutson CO, Hori JM, Spratt JS Jr: Melanoma. *Curr Probl Surg* **12**:3-55, 1971. ☆☆☆

TREAT THE SYMPTOMS IN THE GERIATRIC PATIENT

APATHY • IRRITABILITY
FORGETFULNESS • CONFUSION



Cerebro-Nicin® CAPSULES

A GENTLE CEREBRAL STIMULANT & VASODILATOR FOR GERIATRIC PATIENTS

Each CEREBRO-NICIN capsule contains:
Pentylenetetrazole .....100 mg. • Nicotinic Acid ...100 mg.
Ascorbic Acid .....100 mg. • Thiamine HCl .....25 mg.
l-Glutamic Acid .....50 mg. • Niacinamide .....5 mg.
Riboflavin .....2 mg. • Pyridoxine HCl .....3 mg.
AVAILABLE: Bottles 1DO, 5DD, 1DDO
SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and abdominal cramps. The reaction is usually transient.
INDICATIONS: As a cerebral stimulant and vasodilator.
RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.
WARNING: Overdosage may cause muscle tremor and convulsions.
CONTRAINDICATIONS: Epilepsy or low convulsive threshold.
CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

Write for literature and samples . . .
BROWN THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

OHIO OFFICES:

CINCINNATI: Room 700, 3333 Vine Street, (513) 751-0657, L. A. Flaherty

CLEVELAND: Suite 106, 23360 Chagrin Boulevard, Beachwood 44122, (216) 464-9950

A. C. Spath, Jr., R. A. Zimmerman

COLUMBUS: 1989 West 5th Ave., (614) 486-3939, J. E. Hansel

TOLEDO: 1011 Sandusky St., Suite H, P.O. Box 331, Perrysburg 43551, (419) 874-8080, R. E. Stallter

COLD FEET

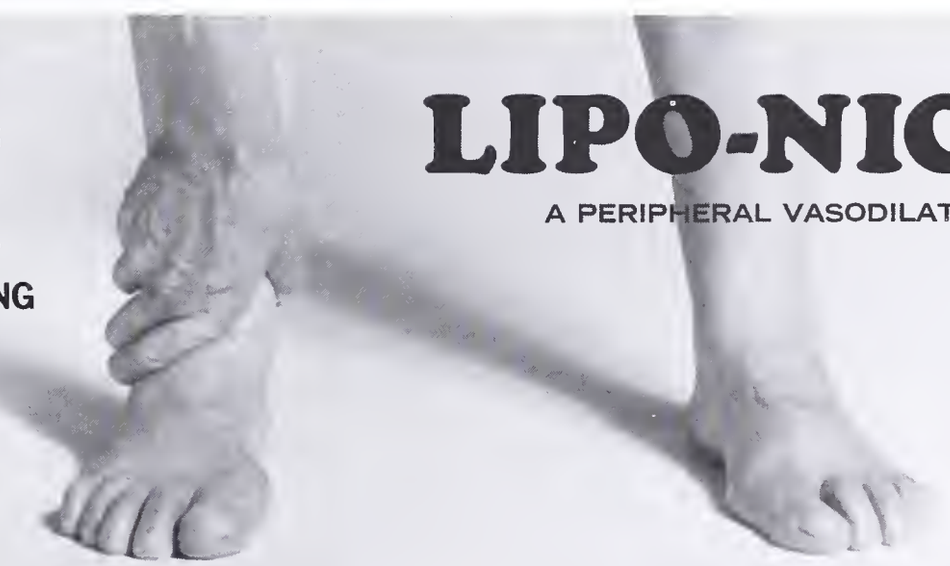
LEG CRAMPS

TINNITUS

DISCOMFORT ON STANDING

LIPO-NICIN

A PERIPHERAL VASODILATOR



IMMEDIATE or GRADUAL

nicotinic acid therapy

IMMEDIATE RELEASE

LIPO-NICIN/100 mg.
Each blue tablet contains:
Nicotinic Acid .....100 mg.
Niaclnamide ..... 75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .. 25 mg.
Riboflavin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6).. 10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500, 1000.

LIPO-NICIN/250 mg.
Each yellow tablet contains:
Nicotinic Acid .....250 mg.
Niacinamide ..... 75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .. 25 mg.
Riboflavin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6). 10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500, 1000.

GRADUAL RELEASE

LIPO-NICIN/300 mg.
Each time-release capsule contains:
Nicotinic Acid .....300 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (H-1) .. 25 mg.
Riboflavin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6).. 10 mg.
In a special base of prolonged therapeutic effect.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient. Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur. Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

BROWN THE BROWN PHARMACEUTICAL CO., INC. 2500 West Sixth Street, Los Angeles, California 90057

Write for Literature and Samples

REFER TO PDR

The Ohio State University

Center for Continuing Medical Education

announces

GERIATRIC CARDIOLOGY

Cardiac and Vascular Diseases in the Elderly

November 29, 1978

Hilton Inn, Olentangy River Road

Columbus, Ohio

This seminar will present information about the important, unique features of geriatric cardiovascular diseases that will enable physicians to improve their capabilities in diagnosis and treatment of elderly patients.

In particular, students of the course will learn the differential aspects of the age-associated alterations in heart structure and cardiovascular hemodynamics which will increase their ability to recognize these phenomena so they can clinically improve detection and application of current diagnostic and therapeutic procedures.

They will learn how to more safely and effectively use medications for cardiovascular diseases by understanding important aspects of the pharmacokinetics of drugs and basic pathogenesis of vascular diseases in the elderly.

This course will teach important clinical features of cardiac arrhythmias, valvular disease, and occlusive vascular disease as seen in the elderly. Physicians will improve their ability to recognize these diseases and to apply noninvasive diagnostic techniques.

Very importantly, and unique to this field, these informative practices will be summarized and placed into the oppropriate context of geriatric care.

FEATURED GUEST SPEAKER

EUGENE STEAD, M.D.

Professor of Medicine, Duke University
Noted Authority on Aging

FEATURED OHIO STATE UNIVERSITY FACULTY

THOMAS G. SKILLMAN, M.D.

Professor of Medicine

For Registration Information

Contact the Center for Continuing Medical Education, A352 Starling Loving Hall, 320 West Tenth Avenue, Columbus, Ohio 43210, phone: 614/422-4985.

Diseases Described by Ohioans

George W. Paulson, M.D.

There are many physicians and scientists with Ohio roots who deserve remembrance by their colleagues. They may be recognized for their clinical, research, educational, or social innovations. These descriptions refer to Ohioans who are remembered eponymically in neurology or related fields.

Rubenstein-Taybi Syndrome (Broad Thumbs and Halluces)[1]

THERE IS NO UNEQUIVOCAL or pathognomonic criteria in the Rubenstein-Taybi syndrome, but there is widespread acceptance of a pediatric syndrome of developmental retardation with broad terminal phalanges of the thumbs and halluces, plus a characteristic facial "gestalt." In addition, stature, head circumference, and bone age are all below the 50th percentile in most cases; and there may be incomplete or delayed descent of the testes in males. The cause of the complex is unknown. No consistent metabolic or genetic defect has been associated with it, nor has there been any apparent relation to maternal or paternal age at gestation. The condition can be detected at birth since the characteristic thumb, hallux, and facial abnormalities can be seen at that time. Heart murmur, mental retardation, absence of the corpus callosum, and other associated findings have been noted in sporadic cases.

Doctor Rubenstein did much of his training in New York City, with graduate training at Harvard and special pediatric studies at Cincinnati. He has been full professor at the University of Cincinnati College of Medicine since 1970 and is a participant in numerous local and national committees. He is the author of many papers that are characterized by keen interest in pediatric malformations, clarity of exposition, and originality of thought.

Sotos' Syndrome (Cerebral Gigantism in Childhood)[2]

Doctor Juan Sotos and others have described what has been called "cerebral gigantism in childhood." Initially, the authors described five children who were exceptionally long at birth and who seemed to grow too rapidly during the first several years of life. The patients' faces were characterized by a downward lateral slant of the eyes, a prominent forehead, and a depression at the bridge of the nose. These features, along with long arms and large feet, made the patients identifiable at sight to the primary authors. Additionally, mental deficiency and generalized clumsiness have been observed in most of the children with cerebral gigantism; but there was no progressive hydrocephalus or focal neurologic deficit. Sexual development was not accelerated, and overall physical condition was said to be normal. The condition was not thought to be inherited and is not related to fibromatosis or other neurologic disorders that can affect growth. The total significance of the syndrome remains obscure; and at present, there is no evidence of any association with other neurologic disorders. There has been very little additional information written about this entity since the primary reports, but it has been determined a separate disorder to be included in several major pediatric neurology texts, including the classic one by Frank Ford.

Doctor Sotos was born in the La Mancha area of Spain and received extensive training in Spain and in the United States, particularly in Boston. Currently, his major contributions are being made at Children's Hospital in Columbus, and he now is the John Champion Professor of Pediatrics at The Ohio State University. He is a member of numerous scholarly medical societies and has published several dozen papers, some of which are outstanding in both material and style of presentation.

Dr. Paulson, Columbus, Neurologist, Riverside Methodist Hospital; and Clinical Professor of Neurology, The Ohio State University College of Medicine.
Submitted February 17, 1978.

The Journal solicits comments from readers regarding other Ohio physicians who have pioneered various areas of medicine since 1796, with particular reference to description and therapy of disease and pioneering operations, instruments, and programs. Please send such comments to R. L. Meiling, M.D., Consulting Medical Editor, 600 S. High St., Columbus, Ohio 43215.

Zollinger-Ellison Syndrome

Doctors Zollinger and Ellison, both of whom taught at The Ohio State University College of Medicine, reported the Zollinger-Ellison syndrome, in 1955 under the label "ulcerogenic syndrome," and hundreds of later case reports have crystallized the clinical pattern.[3] The major clinical features were an intractable ulcerative condition and hypersecretion of gastric mucosa, as well as rapid recurrence of ulceration despite adequate surgical therapy. A nonbeta islet cell tumor of the pancreas was postulated as a major responsible factor with glucagon or similar substances contributing to the hypersecretion. Currently, there are many studies which indicate an overlap with other tumors, with the most common additional tumor found in the parathyroid tissue. Diarrhea is one additional important aspect of the Zollinger-Ellison syndrome not emphasized in the original paper. Other additions and amendations have been made through the years but, as Doctor Zollinger has written, "the passage of time has been kind to the major portions of the original proposals."[4]

Doctor Ellison left Ohio shortly after discovery of the syndrome to become chairman of the Department of Surgery at Marquette University in Milwaukee (now Marquette University School of Medicine). He died in Milwaukee in 1970.

Doctor Robert M. Zollinger has now retired as chairman of the Department of Surgery at The Ohio State University College of Medicine. Known as the "Big Z," he remains active in central Ohio; he is enthusiastic, controversial, and dynamic. He is the author of approximately 300 papers, and sometimes is visiting professor at dozens of institutions in this country and overseas. He has cut a remarkably wide swathe in academic, private, and organizational surgical circles. As a teacher, his forcefulness has been a cause for complaint and his humor a cause for delight. As past president of the American Rose Society, he had demonstrated repeatedly his awareness of the subtleties of hues in flowers, combined with his ability to describe them in the most earthy of terms. He is a local expert on the varieties and sexual habits of gourds and can speak to scientific or lay audiences, with or without preparation, as eruditely on this subject as on a dozen medical topics.

This eponym, The Zollinger-Ellison syndrome, along with Huntington's disease, is one of the few Ohio labels likely to remain permanently embedded in the medical literature.

Huntington's Disease (Chorea)

In a classic article, citing patients treated by his father and his grandfather on Long Island, New York, George Huntington discussed three major aspects of the disease that now bears his name. First, there is a tendency toward intellectual change and dementia, at times linked with suicide or sociopathic behavior. Second, there usually is chorea with onset in adult life and slow deterioration until the time of death. Since the chorea is not universal, Huntington's disease now is considered a more proper name than Huntington's chorea. The third important feature emphasized by Huntington is that the disease has a strong family inheritance and is dominant in pattern. The original presentation at the Meiges and Mason County Medical Meeting is one of the classic descriptions of an inherited disorder.[5] Huntington had first seen the cases studied by his father and grandfather, but it was when he lived in Ohio that he presented his report.

Huntington's disease has been the subject of more reports in the past quarter century than in the preceding 75 years. The basic features of the disease remain as Huntington presented them, and they include mental change, motor abnormalities, and dominant inheritance. In some families, the disease is more rigid than choreic, and there is great variation in the age of onset of the mental symptomatology. There is no certain way to guess who will develop the disease from among those at risk although much of the current research has involved predictive tests. Therapy consists largely of genetic counseling although some amelioration of the chorea is possible through the use of phenothiazines and other psychotropic agents; yet there is no more chance of a cure now than there was when Huntington lived. Huntington's report, presented to a group of practitioners in Ohio in 1872, remains as a challenge to continue the search for more effective therapy and is still a model of clinical observation.

An obscure private practitioner, George Huntington stayed in Ohio for only a few years, but he married an Ohio girl before he returned to the East Coast. Apparently, he felt that there were too many physicians in practice in the area of the "great bend" of the Ohio River. He later developed respiratory troubles and lived both in the mountains of New York and in North Carolina as a quiet and successful private practitioner. He had a keen interest in music and was an amateur artist, but he wrote nothing else of medical significance during his career. The importance of his observations became apparent in his later years, as noted in the very fine monograph by William Osler entitled "On Chorea."[6] Osler was the first scientist to reprint Huntington's original report in its entirety.[7]

Tolosa-Hunt Syndrome of Painful Ophthalmoplegia

In 1961, Doctors Hunt, Meagher, LeFever and Zeman published an article which is the classic description of what is now termed the "Tolosa-Hunt Syndrome."[8] As with the Guillain-Barre (and Strohl) syndrome, all authors of the initial paper were not equally represented in the eponym. Doctor William Hunt and his assistants have studied at least 12 patients with the syndrome, and others also have reported substantial numbers. The basic clinical syndrome consists of unilateral pain, followed several days later by an ophthalmoplegia in one eye. The pain is not a throbbing, intense hemicrania, but steady, boring discomfort behind one eye. Neurologic involvement can include any of the nerves passing through the cavernous sinus, such as the third, fourth, sixth, or the first division of the fifth nerve. Although less commonly affected, the optic nerve also may be involved. The symptoms last for days or weeks and then spontaneously remit. The syndrome,

including the pain, can be exquisitely responsive to steroids; and this is now the major therapy suggested.

Exhaustive studies in the earlier cases have ruled out aneurysm or other arterioventricular malformation as the usual cause.[9] Diabetes and other processes are not at fault although diabetes also can produce a painful ophthalmoplegia from which the patient recovers after several months. The mononeuritis of diabetes conventionally is attributed to an infarct of the nerve produced by arteriosclerosis of the vaso nervorum.

Tolosa's original report included a case in which there was a granulomatous change in the area of the cavernous sinus, and it is Hunt's opinion that this still is the pathologic process in most cases. There is no evidence that the Tolosa-Hunt syndrome represents a trauma, active bacterial infection, aneurysm, or other more dramatic processes. It is of note that the syndrome not only was described and plucked out of a heterogenous group of neurologic disorders that are quite confusing, but that a therapy with steroids is readily available.

Doctor William E. Hunt remains active as the chief of the Department of Neurosurgery at The Ohio State University Hospitals. Locally, he is well known for his erudite and flowery language, charm, and an amazing ability to doze during medical (not surgical) presentations. He is respected highly as a superb technician in the operating room. Doctor Hunt's major research interest has been in clinical neurosurgery, vascular disorders, and most recently, in trauma of the spinal chord. He is involved heavily in most of the neurosurgical organizations of national relevance.

Doctor Tolosa is a neuropathologist in Europe; he has a son who has been trained in neurology in the midwest section of the United States.

References

1. Rubinstein JH, Taybi H: Broad thumbs and toes and facial abnormalities. *Am J Dis Child* **105**:588-608, 1963.
2. Sotos JF, Dodge PR, Muirhead DM, et al: Cerebral gigantism in childhood: A syndrome of excessively rapid growth with acromegalic features and a nonprogressive neurologic disorder. *N Engl J Med* **271**:109-116, 1964.
3. Zollinger RM, Ellison EH: Primary peptic ulcerations of the jejunum associated with islet cell tumors of the pancreas. *Ann Surg* **142**:709-728, 1955.
4. Zollinger RM, Moore FT: Zollinger-Ellison syndrome comes of age. *JAMA* **204**:361-365, 1968.
5. Huntington G: On chorea. *Med Surg Rep (Phil)* **26**:317-321, 1872.
6. Osler W: On *Chorea and Choreiform Affections,* Philadelphia, Blakiston, 1894, p 119.
7. Barbeau, Chase TN, Paulson GW: *Advances in Neurology,* vol 1. Huntington's Chorea, 1872-1972. New York, Raven Press, 1973.
8. Hunt WE, Meagher JN, LeFever HE, et al: Painful ophthalmoplegia. *Neurology* **11**:56-62, 1961.
9. Sondheimer FK, Knapp J: Angiographic findings in the Tolosa-Hunt syndrome: Painful ophthalmoplegia. *Radiology* **106**:105-112, 1973.

☆☆☆

we can provide some form of health insurance to . . .

99%

of OSMA members—regardless of health history

Comprehensive protection is available for you and your family with the OSMA sponsored Hospital Confinement Insurance Plan, comprehensive Major Medical Insurance and the Excess Major Medical Insurance Plan. Also available to Ohio physicians are Disability Income Coverage, Practice Overhead Expense Coverage, Life Insurance and Accidental Death, Dismemberment and Disability Insurance. Choose the plans that fill your insurance needs and send the coupon today for complete details. Or better yet for immediate information, call us collect!

Spencer W. Cunningham
DANIELS-HEAD & ASSOCIATES, INC.
Daniels-Head Building
Portsmouth, Ohio 45662
Telephone 614/354-4561

I have checked the plans in which I am most interested. Please send me complete details on how I can take advantage of this high value insurance protection at low group rates.

OSMA SPONSORED PLANS
- ☐ HOSPITAL CONFINEMENT INSURANCE PLAN
- ☐ COMPREHENSIVE MAJOR MEDICAL INSURANCE
- ☐ EXCESS MAJOR MEDICAL INSURANCE

ALSO AVAILABLE TO OHIO PHYSICIANS
- ☐ DISABILITY INCOME PROTECTION
- ☐ ACCIDENTAL DEATH, DISMEMBERMENT and DISABILITY INSURANCE
- ☐ PRACTICE OVERHEAD EXPENSE PROTECTION
- ☐ LIFE INSURANCE

Name_____
Address_____
City_____
State_____ Zip_____

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

When impotence is due to androgenic deficiency.

Android®/5 mg. Buccal/10 mg. Oral/25 mg. Oral

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric/eunuchoidism, eunuchism/post-puberal cryptorchidism.



Write for new double-blind study reprints and samples.

BROWN **THE BROWN PHARMACEUTICAL CO., INC.**
2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

Report on the OSMA District Meetings

Linda A. Porterfield, Executive Editor

The Ohio State Medical Association held district meetings during the latter part of September and into October. These meetings were convened in response to a resolution passed at the 1978 Annual Meeting calling for more interchange between the OSMA officers, councilors, and staff and the members of the organization.

Each meeting focused on the concerns of the physicians in that district. Officers, councilors, and staff were on hand to answer questions concerning numerous topics. Although the attendance and concerns varied, some topics came to the forefront regularly. This report will highlight the topics of discussion so that all members are aware of them prior to the OSMA/AMA Update, November 29, which will be attended by OSMA delegates and alternate delegates, county society presidents, OSMA officers and councilors, and AMA delegates and alternate delegates.

Mandatory Continuing Education

Continuing medical education as required by House Bill 682 was the subject of much debate. Many physicians are unhappy at being "forced" to complete education that they had been undertaking on a voluntary basis. Some indicated that since the mandating of education, many courses have escalated in cost.

Continuing education is a necessity if a physician wishes to renew his/her license to practice medicine in Ohio. The next renewal date is January 1, 1980; and licenses will be renewed for the period January 1, 1980 through December 31, 1982.

Since most physicians participate in CME as a normal action, it was noted that the additional effort required was the completing and submitting of the "Log of Continuing Medical Education Activities." This log was published in the December 1976 issue of *The Ohio State Medical Journal* and will be reprinted in the December 1978 issue. In addition, copies are available from the OSMA Department of Continuing Medical Education and the Ohio State Medical Board.

The Medical Board has requested that physicians submit this log as soon as they complete the required 150 hours of CME (minimum of 60 hours in Category 1). This is due to the fact that there are over 26,000 physicians currently holding licenses to practice medicine in Ohio. In order to carry out their obligations under the law, the Medical Board needs the cooperation of Ohio physicians in spreading out the paperwork.

In addition, mention was made that the OSMA offers numerous courses that are accredited for Category 1. These courses occur throughout the State of Ohio and are reasonable in cost. In fact, physicians may earn Category 1 credit by reading *The Journal.* (See page 691 this issue, "Estrogen Therapy.")

The December 1978 issue of *The Journal* will be devoted to the mandatory continuing education program. In addition to the log, this issue will contain a review of the mandated program and other related articles. Physicians are urged to retain this issue for reference.

PICO

The Physicians Insurance Company of Ohio (PICO) sent representatives to all of the district meetings to field questions about the Company. Many physicians were concerned about the possibility of lowering malpractice premiums for insurance purchased from the Company. It was pointed out that the amount of liability the Company will incur due to malpractice suits cannot be determined for at least three years from the date of issuance of the Company's first policy. During this same period of time, the company will endeavor to determine the loss figures for Ohio as a whole, in order to base future premiums on Ohio data.

Representatives explained that these reasons are why the Company had to use national figures to determine initial rates. Any adjustments that can be made in these rates are being done (ie, the Company has lifted the corporation surcharge). Currently, PICO insures in excess of 2,500 Ohio physicians and is the largest malpractice carrier in Ohio.

It also was noted that PICO has branched into life, homeowners, automobile, and other coverages in order to broaden the base of the Company and to provide

(continued on next page)

Our 70th Year

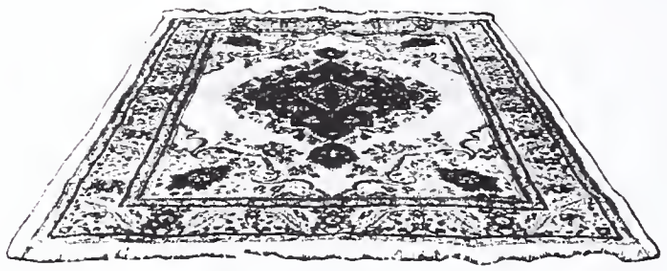
K. A. Menendian
has been known for
the finest quality and best values in
ORIENTAL RUGS.

We carry a complete selection of rugs from mats to mansion sizes. Over 1500 rugs in stock from Iran, India, China, Pakistan, Turkey, etc.

See over 4,000 samples in our newly remodeled carpet showroom from Karastan and other fine mills.

We specialize in Oriental rug cleaning and repairing.

K.A.Menendian
1090 West Fifth Avenue
294-3345



THERE IS A DIFFERENCE!

PREPARE FOR: NAT'L MEDICAL BDS
NAT'L DENT BDS FLEX VQE
ECFMG NAT'L NURSING BDS

Stanley H. KAPLAN
EDUCATIONAL CENTER

Flexible Programs and Hours

CLEVELAND AREA	COLUMBUS AREA	CINCINNATI AREA
14055 Cedar Rd.	1890 N.W. Blvd.	309 Ludlow Ave.
Cleveland, Ohio 44118	Columbus, Ohio 43212	Cincinnati, Ohio 45220
(216) 371-0035	(614) 486-9646	(513) 281-1818

Call Days, Evenings & Weekends

THE test preparation specialists since 1938

District Meetings *(continued)*

OSMA members with additional valuable insurance service. (PICO Life is a wholly owned subsidiary of PICO.) Such moves will provide greater stability through diversification.

Physicians with any questions regarding PICO or PICO Life are encouraged to contact the PICO office at 6100 Channingway Boulevard, Columbus, Ohio 43227, telephone: 614/864-3043.

Membership

A recent membership biographic survey was mentioned with the request that physicians complete and return the form as quickly as possible. OSMA has acquired an inhouse computer and needs the data requested to build its file. (The computer also will be used to record the CME hours of Ohio physicians during the next relicensure triennium.) Some physicians were unsure as to what their medical education numbers were. This number appears above a physician's name on the OSMA membership card and on the AMA membership card. It also was noted that the member's Social Security number is requested as an item of personal identification unique to each individual.

It was noted that dues are now payable for 1979. Physicians are encouraged to affiliate with the American Medical Association as well as the OSMA and their county societies. With the many problems facing medicine today, it is essential that medicine unite behind one strong voice. Recently, the AMA House of Delegates reduced to one half the dues for physicians in their first year of practice. The OSMA Council is drafting a similar resolution affecting OSMA dues which will be presented at the 1979 OSMA House of Delegates.

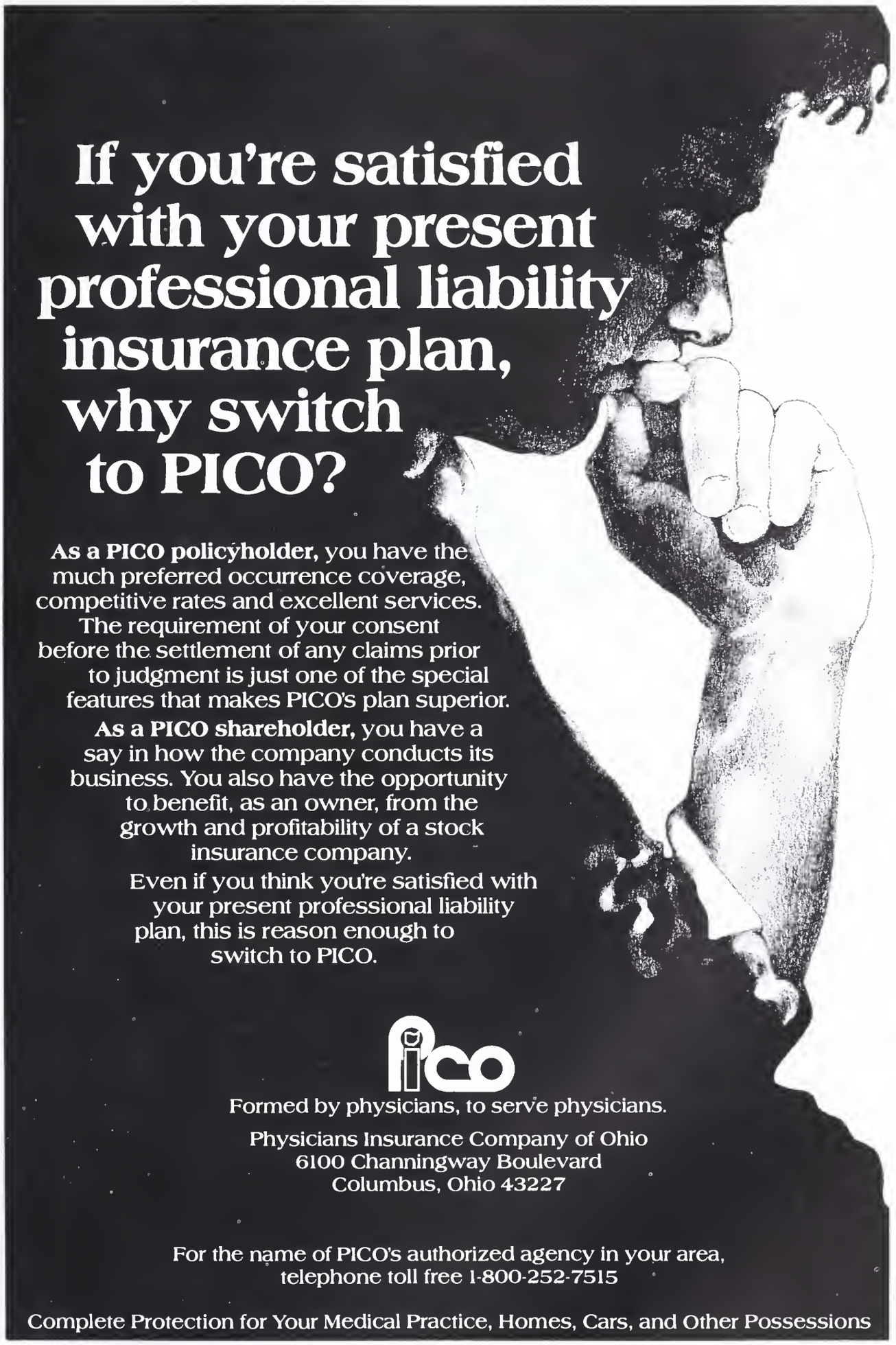
Communication

Through the OSMA Department of Communications, an effort is underway to assist physicians in becoming better spokesmen for medicine. Seminars are being planned incorporating public speaking and current medical topics. Interested physicians from throughout Ohio are needed to discuss concepts with the news media—whether television, radio, or print— and before nonmedical organizations. Anyone willing to join this core group should contact the OSMA Department of Communications at OSMA Headquarters.

Emphasis was placed on the three OSMA publications reaching members each month. These are the channels through which the OSMA endeavors to make activities and actions known to the members at large. Although no member is expected to read each issue cover to cover, it was suggested that a physician check each monthly issue for items of particular interest.

Any member not receiving *The Ohio State Medical Journal, Synergy*— the patient publication—, and the "OSMAgram" should contact OSMA Headquarters.

(continued on page 731)



If you're satisfied with your present professional liability insurance plan, why switch to PICO?

As a PICO policyholder, you have the much preferred occurrence coverage, competitive rates and excellent services. The requirement of your consent before the settlement of any claims prior to judgment is just one of the special features that makes PICO's plan superior.

As a PICO shareholder, you have a say in how the company conducts its business. You also have the opportunity to benefit, as an owner, from the growth and profitability of a stock insurance company.

Even if you think you're satisfied with your present professional liability plan, this is reason enough to switch to PICO.

PICO

Formed by physicians, to serve physicians.

Physicians Insurance Company of Ohio
6100 Channingway Boulevard
Columbus, Ohio 43227

For the name of PICO's authorized agency in your area, telephone toll free 1-800-252-7515

Complete Protection for Your Medical Practice, Homes, Cars, and Other Possessions



If Our Area Manager Isn't In Maybe Our Secretary Can Help

Our Blue Shield professional relations managers are busy people, constantly out calling on doctors and their office staffs. Which means that if you phone, the area manager may not be in at that moment.

However, expert help may still be available. The area office secretaries are trained and capable in providing assistance with the more common and frequent kinds of matters.

They can check on the status or disposition of claims, answer questions about whether a certain service is payable under a specific contract or find out if the patient is a currently enrolled Blue Shield subscriber.

We take our service seriously...all of us.

Blue Shield

Ohio Medical Indemnity, Inc.

6740 North High Street, Worthington, Ohio 43085

District Meetings *(continued)*

Legislation

Physician involvement in the legislative process must increase as medicine becomes the focus of government intervention and control. Both state and national legislative matters were discussed at the meetings. Since issues may change or alter from day to day, physicians should take note of the "Legislative Updates" appearing in *The Journal* each month. In addition, the Department of State Legislation mails its "Legislative Bulletin" weekly to delegates and alternate delegates and county society officers.

In this time of outside intervention in the practice of medicine, it is most important that physicians become involved in the legislative process.

Conelusion

This report represents the most frequently discussed topics at the recent district meetings. Other issues were brought forth, and the OSMA Staff stands ready to review these as well as to expand on the aforementioned topics. For further information, contact OSMA Headquarters, 600 South High Street, Columbus, Ohio 43215, telephone: 614/228-6971. ☆☆☆

U S POSTAL SERVICE

STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION

(Required by 39 U S C 3685)

1. TITLE OF PUBLICATION	A. PUBLICATION NO.	2. DATE OF FILING
Ohio State Medical Journal		Sept. 13, 1978
3. FREQUENCY OF ISSUE	**A. NO. OF ISSUES PUBLISHED ANNUALLY**	**B. ANNUAL SUBSCRIPTION PRICE**
Monthly	12	$10 Domestic

4. LOCATION OF KNOWN OFFICE OF PUBLICATION *(Street, City, County, State and ZIP Code) (Not printers)*
900 E. State Street, Athens, Ohio 45701 (Athens County)

5. LOCATION OF THE HEADQUARTERS OR GENERAL BUSINESS OFFICES OF THE PUBLISHERS *(Not printers)*
600 S. High Street, Columbus, Ohio 43215 (Franklin County)

6. NAMES AND COMPLETE ADDRESSES OF PUBLISHER, EDITOR AND MANAGING EDITOR

PUBLISHER *(Name and Address)*
Ohio State Medical Association, 600 S. High Street, Columbus, Ohio 43215

EDITOR *(Name and Address)*
Linda A. Porterfield, 600 S. High Street, Columbus, Ohio 43215

MANAGING EDITOR *(Name and Address)*
Hart E. Page, 600 S. High Street, Columbus, Ohio 43215

7. OWNER *(If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual must be given.)*

NAME	ADDRESS
Ohio State Medical Association A non-profit corporation with no stock outstanding.	600 S. High Street, Columbus, Ohio 43215

8. KNOWN BONDHOLDERS, MORTGAGEES, AND OTHER SECURITY HOLDERS OWNING OR HOLDING 1 PERCENT OR MORE OF TOTAL AMOUNT OF BONDS, MORTGAGES OR OTHER SECURITIES *(If there are none, so state)*

NAME	ADDRESS
None	

9. FOR COMPLETION BY NONPROFIT ORGANIZATIONS AUTHORIZED TO MAIL AT SPECIAL RATES *(Section 132.122, PSM)*
The purpose, function, and nonprofit status of this organization and the exempt status for Federal income tax purposes *(Check one)*

☒ HAVE NOT CHANGED DURING PRECEDING 12 MONTHS ☐ HAVE CHANGED DURING PRECEDING 12 MONTHS *(If changed, publisher must submit explanation of change with this statement.)*

10. EXTENT AND NATURE OF CIRCULATION	AVERAGE NO. COPIES EACH ISSUE DURING PRECEDING 12 MONTHS	ACTUAL NO. COPIES OF SINGLE ISSUE PUBLISHED NEAREST TO FILING DATE
A. TOTAL NO. COPIES PRINTED *(Net Press Run)*	12,242	12,400
B. PAID CIRCULATION 1. SALES THROUGH DEALERS AND CARRIERS, STREET VENDORS AND COUNTER SALES	88	0
2. MAIL SUBSCRIPTIONS	11,595	11,815
C. TOTAL PAID CIRCULATION *(Sum of 10B1 and 10B2)*	11,683	11,815
D. FREE DISTRIBUTION BY MAIL, CARRIER OR OTHER MEANS, SAMPLES, COMPLIMENTARY, AND OTHER FREE COPIES	301	346
E. TOTAL DISTRIBUTION *(Sum of C and D)*	11,984	12,161
F. COPIES NOT DISTRIBUTED 1. OFFICE USE, LEFT OVER, UNACCOUNTED, SPOILED AFTER PRINTING	258	239
2. RETURNS FROM NEWS AGENTS	0	0
G. TOTAL *(Sum of F1 and 2—should equal net press run shown in A)*	12,242	12,400

11. I certify that the statements made by me above are correct and complete

SIGNATURE AND TITLE OF EDITOR, PUBLISHER, BUSINESS MANAGER, OR OWNER
Linda A. Porterfield

12. FOR COMPLETION BY PUBLISHERS MAILING AT THE REGULAR RATES *(Section 132.121, Postal Service Manual)*

39 U S C 3626 provides in pertinent part: "No person who would have been entitled to mail matter under former section 4359 of this title shall mail such matter at the rates provided under this subsection unless he files annually with the Postal Service a written request for permission to mail matter at such rates."

In accordance with the provisions of this statute, I hereby request permission to mail the publication named in Item 1 at the phased postage rates presently authorized by 39 U S C 3626.

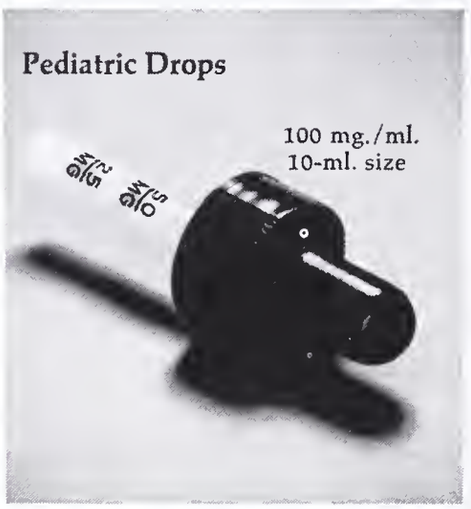
SIGNATURE AND TITLE OF EDITOR, PUBLISHER, BUSINESS MANAGER, OR OWNER



easy to take







Keflex®
cephalexin

Lilly

Additional information available to the profession on request.
Eli Lilly and Company
Indianapolis, Indiana 46206

500738

Classified Ads

Rates: $3 per line. Display classified: $5 per line. Minimum 3 lines per insertion. Ads measure 8 lines to the inch. Box number reply: Flat $5 charge in addition to line cost for up to and including three insertions. (Covers cost of mailing replies which are kept confidential.) Forms close the 10th day of the month preceding month of publication. Address all ads Attention: Classified Ad Department, ***The Journal.***

To assure prompt delivery, when replying to an advertisement over a ***Journal*** box number, address letters as follows: Box (insert number), c/o ***The Ohio State Medical Journal***, 600 South High Street, Columbus, Ohio 43215.

PHYSICIAN NEEDED: For resort community in magnificent sunbelt setting. Enjoy superb golf, tennis, sailing, riding, fishing, hunting, and all water sports. Start with a guaranteed salary and benefit package. No investment required; but in two years, you can own your own practice including medical and office equipment and office furniture purchased at book value. Benefits include liberal vacation. Study time with travel expenses paid, and paid malpractice, health, accident, and life insurance. For more information, write Don Small, Fairfield Bay Medical Center, Box 3008, Fairfield Bay, Arkansas 72088, or call toll-free 800/643-9790 or 643-9791 (in Arkansas, call 501/884-6334).

FOR SALE: Forced to close my office because of myocardial infarction. Have 46 pieces of furniture and equipment for sale. Replacement value $8,500. Make offer. For list of items, write 6598 Devonwood Dr., Cincinnati, Ohio 45224.

GENERAL PRACTICE PHYSICIAN WANTED: Office space available. $100,000 first-year potential. Northcentral Ohio, population area 25,000. Ideal environment, excellent sports, recreational facilities, boating nearby. Midway Cleveland-Toledo, 100 miles north Columbus. Modern 68-bed hospital. Good schools. Brochure on request. Write T. R. Ball, M.D., Box 309, Bellevue, Ohio 44811.

NEEDED: Creative physician-educator to assume an excellent position and opportunities as Associate Director of a family practice program which is part of a 30-physician residency. This center is located within the new Medical Tower adjacent to an 1,150-bed teaching hospital in Indianapolis, Indiana. Excellent salary and benefits available. For further information, send C.V. to: Director of Family Practice Education, Methodist Hospital, 1604 North Capital Avenue, Indianapolis, Indiana 46202.

HOUSE PHYSICIAN WANTED: For a community hospital located in Northeast Ohio. Attractive fringe benefits, including insurance. Salary negotiable. Must have Ohio licensure. Reply Box 842 c/o Ohio State Medical Journal.

ON CRESCENT BEACH!: Deluxe ocean-front two-bedroom condominium on Siesta Key, Sarasota, Florida. Tennis, pool, sandy white beach. For information, write: M.C.-Condo, P.O. Box 2364, Dayton, Ohio 45429.

INTERNIST OR GENERAL PRACTICE PHYSICIAN: For the staff of a health care facility in a city of 43,000 in north central Indiana. Permanent license in any U.S. state required. Salary open to $47,025 depending on qualifications and experience. Special bonus pay is available in addition. Thirty days vacation; 15 days sick leave; 9 paid holidays; low-cost life and health insurance; malpractice insurance furnished; excellent retirement plan. Moving expenses paid. EOE. Contact: Personnel Service, VA Medical Center, Marion, Indiana 46952, phone: 317/674-3321, Ext. 419 Collect.

MARION, OHIO: Excellent opportunities in Central Ohio. Existing and new, solo, partnerships, or association practices available and seeking physician support. Top compensation— reliable cross coverage. Exceptionally attractive, 225-bed, well-equipped regional medical center hospital within walking distance from offices. Industry and agriculture support city/45,000; county/65,000; and total trade area/250,000. Excellent schools and residential areas. Fifty-minute, easy drive to Columbus. Active need for—

FAMILY PRACTICE
INTERNAL MEDICINE
OTOLARYNGOLOGY
PEDIATRICS
INDUSTRIAL/OCCUPATIONAL
EMERGENCY MEDICINE

We are seeking either rural or city-oriented physicians. Send C.V. or contact— **ROBERT FLINT**, Marion General Hospital, **MARION, OHIO** 43302 — or call 614/387-8810 or 387/5442 any time.

INTERNIST: Twenty-nine year old FMG seeks relocation. Available immediately. Reply Box 844 c/o Ohio State Medical Journal.

FAMILY PRACTICE FOR SALE: Eight-year-old family practice to settle young doctor's estate, Piqua, Ohio, 35 miles north of Dayton, Ohio on Interstate 75, population of approximately 20,741. Can arrange for leasing of office and either purchase or leasing of equipment. Contact John G. Duffy, Trust Officer, Winters National Bank and Trust Co., Executor, Winters Bank Tower, Sixth Floor, Dayton, Ohio 45401.

YOUNG INTERNIST: Born and trained in Ohio, seeks practice opportunity in Cleveland, Columbus, Cincinnati, Dayton or Toledo for July 1979. Reply Box 843 c/o Ohio State Medical Journal.

BEAT THE WINTER: Come to the sunbelt. Our clients range from solo practitioners seeking associates, to single and M/S group expansions, to practices being vacated by retiring physicians. These situations offer excellent growth, low crime, warm climate, varied recreational activities, and attractive income and perk packages. For assistance in your move and/or opportunities in your specialty send your CV to MEDICAL SEARCH, 3955 Pleasantdale Road, Atlanta, Georgia 30340.

EMERGENCY PHYSICIAN POSITION AVAILABLE: New medical center in Wheeling, West Virginia, adjacent to Interstate 70 just one hour from Pittsburgh. Good salary and executive fringe benefit package including paid educational time off and educational allowance. Congenial staff and outstanding relationship between staff and administration. Area offers cultural and recreational opportunities, including well-known Oglebay Park, without big city problems. Send curriculum vitae to G. M. Kellas, M.D., Medical Director, Wheeling Hospital, Medical Park, Wheeling, WV 26003, phone: 304/242-7870.

PLACEMENT OPPORTUNITIES: Ohio, Pennsylvania. Excellent positions available now and in the near future for private, group, and hospital-associated practices in Internal Medicine, Urology, Ophthalmology, Family Practice, General Surgery, Orthopedics, Pediatrics, Psychiatry, and Otolaryngology. Confidential service by licensed placement agency. No fees charged to you. For details, forward C.V., etc. to Box 845 c/o Ohio State Medical Journal.

(Classified Ads continued on next page)

FAMILY PHYSICIAN WANTED: Small town in southwestern Ohio. 50 miles from Cincinnati and 50 miles from Columbus. Nice friendly town and large surrounding farming area— collections good. Hospital within ten miles. Practice and fully equipped office. May be bought or leased. Available January 1, 1979. Call 513/780-4424.

DERMATOLOGY PRACTICE: Five-year, well-established practice. Good location in suburb of Cleveland. Potential is great. Present gross income over $100,000. Terms negotiable. Please write: 32915 Aurora Rd., Solon, Ohio 44139 or phone: 216/248-4827.

NEW OFFICE SPACE: Available in rapidly growing area of Ohio, 25 miles west of Cleveland, one block from a newly expanded 400-bed hospital. Please call 216/322-3947 or 216/323-8458 for further information.

AVAILABLE: Long-established physician's office for rental or property purchase. Excellent practice opportunity for general practitioner. Twenty-seven miles west of Cleveland. Retiring. Reply to: R. DeMarco, M.D., 329 Vassar Ave., Elyria, Ohio 44035.

ATHENS: Emergency Department Physician practice available. Minimum guarantee/fee-for-service. Income $50,000-$65,000. Contact James Ginter, Regional Director, Physicians Placement Group, Inc., 931 Chatham Road, Columbus, Ohio 43221, or call 614/457-9761.

CARDIOLOGIST WANTED: Northwest Ohio. Board certified or eligible to join a busy consulting practice. Performing echos, phonos, treadmill, VCG, Holter, and rehabilitation. Participate in three hospital consultation, C.C.U. and catheterization. Teaching position available. Salary negotiable. Reply to Box 839 c/o Ohio State Medical Journal.

EMERGENCY MEDICINE: Ohio and western Pennsylvania. Occasional part-time or full-time work available. Excellent remuneration and flexible scheduling. Ohio or Pennsylvania license required. Contact: James Ginter, Regional Administrator, 931 Chatham Lane, Columbus, Ohio 43221, phone: 614/457-9761.

AMBULATORY CARE CENTER — EMERGENCY DEPARTMENT STAFF PHYSICIAN, ATHENS, OHIO: 20,000 annual patient visits. Flexible scheduling, minimum guarantee/monthly bonus, excellent fringes. Contact Eric Jenison, M.D., O'Bleness Memorial Hospital, Athens, Ohio 45701, or call toll-free 800/325-3982 for details.

GENERAL MEDICAL OFFICES AVAILABLE FOR RENT: In Hartville, reportedly the fastest growing township in Ohio. New construction permitting individual furnishing. Physically attached to Cancer Center with diagnostic x-ray, laboratory, and pharmacy facilities. Contact George N. Swallon Agency, Canton, Ohio, 216/456-3495, or inquire of R. K. Loeffler, M.D., 650 South Prospect, Hartville, Ohio 44632.

EMERGENCY PHYSICIANS: Full-time, immediate-and-near-future openings exist in Ohio and Pennsylvania. Excellent pay, benefits, and malpractice insurance. E.R. experience and state licensure required. For details, forward C.V., etc., to Box 846 c/o Ohio State Medical Journal.

PEDIATRICIAN WANTED: For 47-physician multispecialty group located in a prosperous Central Ohio community. Present Department includes four pediatricians providing 37,000 outpatient visits yearly. Attractive salary and unusual fringes, including retirement program; early partnership with no financial investment. Send C.V. or call collect to Albert N. May, M.D. or Bruce Dyer, Executive Director, F. C. Smith Clinic, 1040 Delaware Avenue, Marion, Ohio 43302, phone 614/387-0850.

GARFIELD HTS., OHIO: Immediate position available for full-time physician with background in emergency care, family practice, medicine, or surgery in our new emergency facility of 300-bed hospital with complete specialty backup. Paid vacations, malpractice and health insurance, plus pension plan. Contact: Victor Koludrovich, M.D., 12300 McCracken Rd., Garfield Hts., Ohio 44125, phone: 216/581-0500 or 524-7753.

PHYSICIANS— ALL SPECIALTIES: Opportunities available in solo, group, or staff positions. Fee for service with a guarantee or salaried incomes. Call now for listing of prime locations throughout the country. Call 216/663-4700, Diane Sinchak at Roth Young Personnel, 5333 Northfield Rd., Bedford Hts., Ohio 44146.

PEDIATRICIAN, OB-GYN, INTERNIST & SURGEON: Board-eligible or certified. Needed immediately for established multispecialty group in mid-Ohio community of 60,000, next to 500-bed hospital. Liberal payment and benefits. Contact: J. Harold King, M.D., 295 Glessner Ave., Mansfield, Ohio 44903, phone 419/525-1111.

FAMILY PRACTICE — RURAL PRACTICE: Northwest/central rural/agrarian community of 1200/1500 needs family practice physician. Practice could expand to cover 3000/3500 population area. No physician now practicing. Community will support. Major regional hospital within driving distance. Contact *ROBERT FLINT,* **MARION HOSPITAL, MARION, OHIO** 43302, phone: 614/387-8810 or 387-5442.

CARDIOLOGIST/INTERNIST: Southwestern Ohio group seeks C.V. board-certified/eligible cardiologist to join four cardiologist/internists in the practice of full-range clinical cardiology including invasive procedures. Desire July 1979 availability. Liberal salary and fringe benefits including malpractice insurance. Reply with CV to Box 841 c/o Ohio State Medical Journal.

journal Advertisers

Breon Laboratories, Inc.....716
Brown Pharmaceutical Company, Inc. 720, 721, 726
Burroughs Wellcome Co.....731

Daniels-Head & Associates, Inc.....725

Frank B. Hall & Co. of Ohio, Inc.....688

Hempel Financial Corporation.....683
Home Marketing of America/ Summit Chase.....690
Hurley Medical Center.....714

Immke Circle Leasing.....680
International Travel Advisors.....678

Lilly, Eli and Company.....732

Mead Johnson Pharmaceutical Division 709, 710
Medical Protective Company.....721
Menendian Carpets.....728

Ohio Medical Indemnity.....730
Ohio State University College of Medicine.....677, 722

PBP Data Systems.....681
Physicians Insurance Company of Ohio, Inc.....729
PICO Life.....682
Practice Productivity.....687

Roche Laboratories, Div. of Hoffmann-LaRoche, Inc. .....672, 673, Cover 2, Cover 3, Cover 4

Smith, Kline and French Labs.....674, 675
Stanley H. Kaplan Educational Center....728
Summit County Medical Service Bureau..686

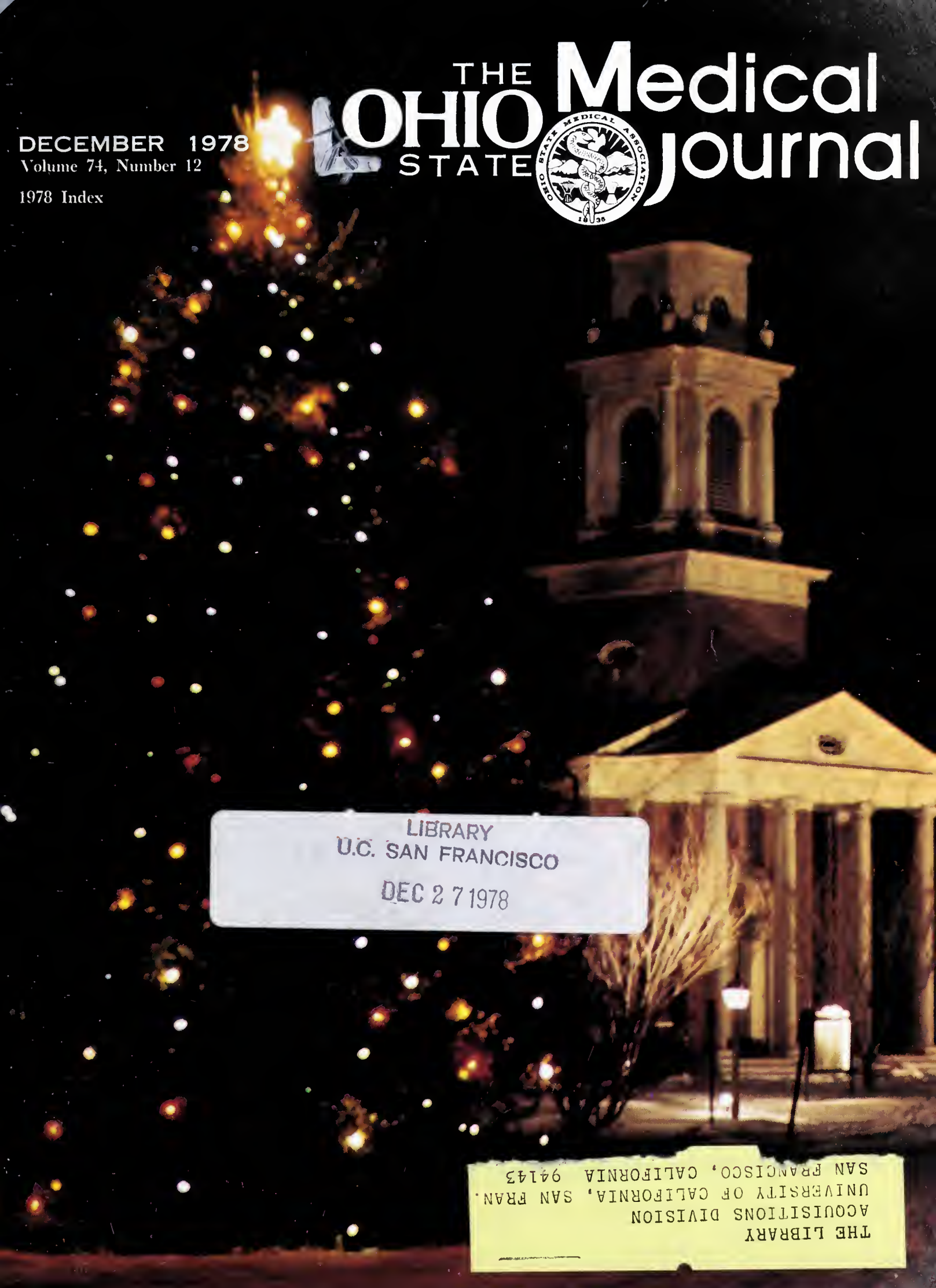
Turner & Shepard, Inc.....715

Upjohn Pharmaceutical Company.....684

Windsor Hospital.....714

DECEMBER 1978
Volume 74, Number 12
1978 Index

THE OHIO STATE Medical Journal



LIBRARY
U.C. SAN FRANCISCO
DEC 2 7 1978

THE LIBRARY
ACQUISITIONS DIVISION
UNIVERSITY OF CALIFORNIA, SAN FRAN.
SAN FRANCISCO, CALIFORNIA 94143

PUBLISHED BY THE OHIO STATE MEDICAL ASSOCIATION

THE MESSAGE OF TENSION



HEADACHES
SWEATS
TENSE, TAUT MUSCLES
HYPERVENTILATION
TACHYCARDIA
PALPITATIONS
BURNING IN STOMACH
FULLNESS
FREQUENCY

to relieve psychic tension and its functional symptoms

VALIUM®
(diazepam)®

2-mg, 5-mg, 10-mg scored tablets

VALIUM®(diazepam)

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Tension and anxiety states, somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).
The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

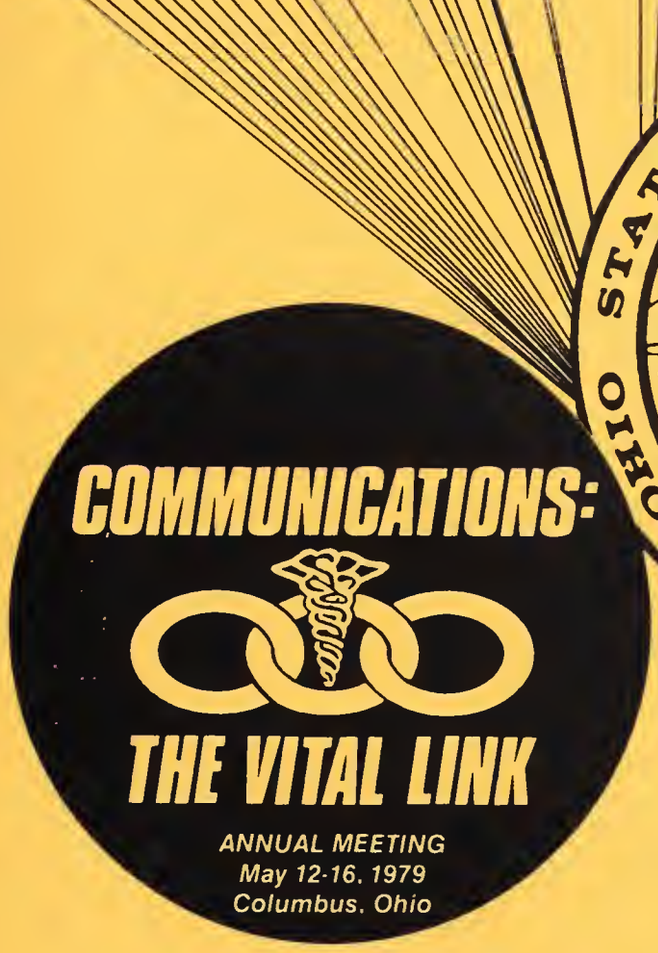
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

ANNUAL MEETING





1979

May 12, 13, 14, 15 and 16

Sheraton Motor Hotel

Veterans Memorial Auditorium

Columbus, Ohio

Announcing the . . .

1979 Ohio State Medical Journal Photographic Exhibit

The Ohio State Medical Journal is sponsoring its second juried-and-judged photographic exhibit. Unlike the 1978 exhibit, the 1979 Ohio State Medical Journal Photographic Exhibit is open to physicians and their spouses. Those persons submitting winning entries will receive awards at the 1979 OSMA Annual Meeting, Columbus, where the entries will be displayed. Subsequently, winning entries may be published in *The Journal*.

Photographs may be entered in two divisions: (1) BLACK AND WHITE and (2) COLOR. Each division has two categories: (1) GENERAL and (2) SCIENTIFIC.

Entries must be in print form (8" x 10" or 11" x 14" in size) and should be mounted on print board or otherwise submitted for ease of display on a peg board. Photographs must be previously unpublished, and right to publish the photograph must be given to *The Journal* at the time the photograph is entered in the exhibit.

The Lima Art Association has requested a winter date to display the 1979 Journal Photographic Exhibit, so entries will be retained through that time unless the entrant requests prior return of his/her photograph on the entry form.

An OSMA member or spouse may submit as many entries as he/she wishes. Each entry must be accompanied by an entry form and a $5 entry fee. Entries should be mailed or hand carried to *The Journal* Office.

All entries must be received by *The Journal* Office no later than *March 30, 1979.*

1979 THE OHIO STATE MEDICAL JOURNAL PHOTOGRAPHIC EXHIBIT ENTRY FORM

NAME_____ IF NONMEMBER, SPOUSE'S NAME_____

STREET_____

CITY_____ STATE_____ ZIP CODE_____ COUNTY_____

DIVISION:	Black and White____	Color____
CATEGORY:	General____	Scientific____
PROCESSING & PRINTING:	Professional____	Self____

INFORMATION ABOUT PHOTOGRAPH (provide as much as possible):

Camera_____ Lens_____ Aperture_____

Speed_____ Film Type_____

Subject_____ Date_____ Time of Day_____

Title of Photograph_____

I GIVE THE JOURNAL PUBLICATION RIGHTS TO THIS PHOTOGRAPH. I CERTIFY THAT THIS PHOTOGRAPH HAS NOT BEEN PUBLISHED PREVIOUSLY AND THAT I WILL NOT SUBMIT IT FOR PUBLICATION ELSEWHERE PENDING THE JUDGING OF THE PHOTOGRAPHIC EXHIBIT. ALSO, I CERTIFY THAT ANY PERSON(S) PICTURED HAVE GIVEN ME AUTHORIZATION TO ALLOW PUBLICATION OF HIS/HER PHOTOGRAPH.

_____(sign)

My photograph may be retained for post-Annual Meeting display. ☐ yes ☐ no

Mail or hand carry the photograph, entry form, and $5 entry fee **(make checks payable to The Ohio State Medical Journal)** to: The Ohio State Medical Journal Photographic Exhibit, 600 South High Street, Columbus, Ohio 43215.

All entries must be received no later than March 30, 1979.

Please be sure the photograph is securely wrapped to avoid bending.

(This Form May Be Duplicated)

OSMA OFFICERS

President
JOHN J. GAUGHAN, M.D.
7911 Detroit Avenue
Cleveland 44102

President-Elect
THOMAS W. MORGAN, M.D.
P.O. Box 344
Gallipolis 45631

Past President
WILLIAM M. WELLS, M.D.
241 Hudson Avenue
Newark 43055

Secretary-Treasurer
ROBERT G. THOMAS, M.D.
630 East River Street
Elyria 44035

EDITORIAL STAFF

Consulting Medical Editor
Richard L. Meiling, M.D.

Managing Editor and Business Mgr.
Hart F. Page

Executive Editor and Executive Business Manager
Linda A. Porterfield

Editorial Assistant
Mary Lou Brady

Communications Editor
Rebecca J. Doll

Continuing Medical Education Editors
Gail E. Dodson
David C. Torrens

Federal Legislation Editor
Charles W. Edgar

Field Service Editor
Robert E. Holcomb

Government Relations Editor
Herbert E. Gillen

Health Education Editor
Robert D. Clinger

Membership Editor
Katherine E. Wisse

Organization Services Editor
Jerry J. Campbell

State Legislation Editors
D. Brent Mulgrew, J.D.
Richard A. Ayish

Address All Correspondence, Address Change, & Reprint Request (unless otherwise noted): Executive Editor, The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215. Phone: 614/228-6971.

Published monthly under the direction of The Council for and by members of The Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215, a scientific society, nonprofit organization, with a definite membership for scientific and educational purposes.

1979 Subscription: $15 per year, single copy $2 (outside U.S. $20 and $3).

Entered as second class matter July 5, 1905, at the Post Office at Athens, Ohio, under the Act of Congress of March 3, 1879. Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918. Second-Class Postage Paid at Athens, Ohio.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertisers must conform to policies and regulations established by The Council of the Ohio State Medical Association.

Publication office: 900 East State Street, Athens, Ohio 45701.

Printed by
The Lawhead Press, Inc., Athens, Ohio

VOL. 74 DECEMBER 1978 NO. 12

OHIO STATE MEDICAL JOURNAL

Ohio Law Requires Continuing Medical Education

OSMA ASSISTS PHYSICIANS IN MEETING THE STATE MANDATE 745
Carl E. Spragg, M.D., New Concord

JANUARY 1, 1977 - DECEMBER 31, 1979 THE DAYS OF THE FIRST TRIENNIAL REGISTRATION OF OHIO MEDICAL LICENSES 748
Linda A. Porterfield, Gail E. Dodson, and David C. Torrens, Columbus

LOG OF CONTINUING MEDICAL EDUCATION ACTIVITIES 755

FREQUENT QUESTIONS REGARDING MANDATORY CONTINUING EDUCATION 762

CONTINUING MEDICAL EDUCATION FOR OSTEOPATHIC PHYSICIANS 766
Evelyn L. Cover, D.O., Columbus

DEATH AND DYING 769
Joan S. Fulton, Columbus

A SIX-YEAR BIOGRAPHIC STUDY OF MEDICAL STUDENTS AT THE OHIO STATE UNIVERSITY 774
Lawrence L. Gabel, Ph.D., and J. Hutchison Williams, M.D., Columbus

PLANNING AND DOCUMENTING CONTINUING EDUCATION IN THE COMMUNITY HOSPITAL 779
David S. Stein, Ph.D., and John P. Shultz, M.D., Columbus

Special

1979 OHIO STATE MEDICAL JOURNAL PHOTOGRAPHIC EXHIBIT 736

NOTICE TO ALL OSMA MEMBERS 739

OHIO STATE MEDICAL JOURNAL CUMULATIVE INDEX FOR VOLUME 74 (1978) 793

Features

Manuscript Guidelines 738
Letters to the Editor.....741
Obituaries 743
News 783
New Members.....786
Colleagues in the News.....788
Classified Ads 790
Journal Advertisers 791

COVER: "Seasons Greetings" from the officers, councilors, and staff of the Ohio State Medical Association. (Photograph by D. Brent Mulgrew, J.D., Director, OSMA Department of State Legislation, and member, 1979 ***Ohio State Medical Journal*** Photographic Exhibit Committee.)

Copyright 1978. The Ohio State Medical Association. All material subject to this copyright may be photocopied for the noncommercial purpose of scientific or educational advancement.

THERE IS A DIFFERENCE!
PREPARE FOR: NAT'L MEDICAL BDS
NAT'L DENT BDS FLEX VQE
ECFMG NAT'L NURSING BDS
Stanley H. KAPLAN
EDUCATIONAL CENTER
Flexible Programs and Hours

CLEVELAND AREA	COLUMBUS AREA	CINCINNATI AREA
14055 Cedar Rd. Cleveland, Ohio 44118 (216) 371-0035	1890 N.W. Blvd. Columbus, Ohio 43212 (614) 486-9646	309 Ludlow Ave. Cincinnati, Ohio 45220 (513) 281-1818

Call Days, Evenings & Weekends
THE test preparation specialists since 1938

Ohio Career Schools Inc.
MAKE YOUR PRACTICE PERFECT
OHIO CAREER SCHOOLS IS READY TO MEET YOUR NEEDS WITH QUALIFIED MEDICAL ASSISTANTS
WE HAVE GRADUATES FROM OUR 3 AFFILIATED SCHOOLS!

AKRON	COLUMBUS NORTH	COLUMBUS EAST
AKRON INSTITUTE OF MEDICAL AND DENTAL ASSISTANTS	COLUMBUS PARAPROFESSIONAL INSTITUTE	COLUMBUS PARAPROFESSIONAL INSTITUTE
733 West Market St. Akron, OH 44303 (216) 762-9788	4820 Indianola Ave. Columbus, OH 43214 (614) 885-9460	70 Robinwood Dr. Whitehall, OH 43213 (614) 221-4481

OR CALL
OHIO CAREER SCHOOLS INC., 4800 Indianola Avenue
Columbus, OH 43214 (614) 885-9460

Ohio State Medical Journal Manuscript Guidelines

1. **EXCLUSIVE PUBLICATION.** Articles are accepted for publication with the understanding that they are contributed solely to this *Journal*. Permission for subsequent publication elsewhere must be obtained in writing from the Editor and from the Author.

2. **CORRESPONDENCE.** Address all correspondence relating to publication of scientific papers to: The Consulting Medical Editor, The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

3. **MANUSCRIPTS.** (a). Manuscripts should be submitted *in the original* on standard 22 × 28-cm (8½ × 11-inch) white typing paper.

(b). A copy of the manuscript should be retained by the Author.

(c). *The entire text including lists of REFERENCES should be TYPED DOUBLE OR TRIPLE SPACED with margins of at least one inch on all sides.*

(d). Tables, charts, and figures (illustrations) should be submitted separately from the text. They should be identified by number and by concise, descriptive titles. In the text, reference to them should he by number, eg, (Fig. 1).

4. **ILLUSTRATIONS.** (a). Illustrations (photographs, drawings, graphs, and tables) will be submitted to the printer for an estimate of cost. *The Journal* will assume $10 of this expense and the author will be billed by *The Journal* for the remainder.

(b). Each illustration should bear the figure number and the author's name on the back. When pertinent, the top of the photograph should be indicated. Do not clip, write on the back with a hard pencil, or otherwise mutilate the prints.

(c). Legends for the figures should be written on separate paper.

(d). The author must affirm that he has *written releases* on all photographs in which patients can be identified.

5. **ABSTRACTS.** *A short* (100-word maximum) abstract should be included with the article. It should cover the main points so that the reader may readily obtain the gist of the article.

6. **SUMMARIES.** The summary should be a concise restatement of the information given in the body of the article.

7. **REFERENCES.** (a). Lists of references should be at a minimum to conserve space and expense and be limited to those essential to the subject and to which actual reference is made in the text. The Editor reserves the right to reduce the number when necessary.

(b). References should be listed in the *order of their appearance in the text.*

(c). Authenticity and accuracy are the responsibilities of the Author.

(d). Each journal reference should include in this order: Author's last name and initials, title of article, name of journal (abbreviated in accordance with standard usage), volume number, inclusive page numbers, and year.

"2. Doe J, Roe RX: How to go about it. Ohio State M J 13:24-30, 1920"

Each textbook reference should include, in this order: Author's surname and initials, title of the book (capitalize all main words), edition, place of publication, name of the publisher, year of publication, volume, if more than one has been published, and page.

"5. Osler W: Modern Medicine. ed 3, Philadelphia, Lea & Febiger, 1927, vol 5, p 66."

8. **IDENTIFICATION OF PATIENTS.** Names, initials, hospital numbers, or any other identifiable labels, should *not* be used. It is preferable to identify patients for the purpose of publication hy the use of numbers in series for the study being reported.

9. **METRICATION.** All measurements must be in metric units. English units should be given in parentheses following the metric in all cases where the measurement was originally done in English units.

10. **EDITING OF MANUSCRIPT.** Following acceptance of a manuscript for publication, it will be copy edited in conformance with the editorial standards of the American Medical Association, which *The Journal* follows. The copy-edited manuscript will be returned to the Senior Author for approval. At that time, he is asked to make all corrections and to have the manuscript retyped. Any changes, other than typographical errors, made by the Author after the manuscript is set in type will be billed to him at $1 per line.

11. **REPRINTS.** An order blank for reprints with a table covering cost will be sent with the galley proofs to the Senior Author. *The Journal* does not profit on reprint orders.

12. **EDITORIAL ASSISTANCE.** Miss Mary Lou Brady, *Journal* Editorial Assistant, stands ready to assist the Author in preparing his manuscript. For his own assistance, however, the Author is encouraged to consult standard texts on medical writing, such as the *Style Book and Editorial Manual,* prepared by the Scientific Publications Division, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

NOTICE TO ALL OSMA MEMBERS

Biographical Survey:

A biographical form was sent to you with the September *OSMAgram*. The purpose of this survey is to build an accurate data base on the OSMA computer for each Association member. The computer file will be used for multiple purposes including addressing of all publications, dues billing for county societies requesting this service, membership record keeping, AMA dues certification, licensure record, and continuing medical education planning and record keeping.

Please return the form to the OSMA office NOW.

If you have not received your copy of the biographical form, call Mrs. Katherine Wisse, OSMA Comptroller, at the Headquarters Office, phone: 614/228-6971.

Membership Dues:

Your membership in the Ohio State Medical Association and the American Medical Association, including subscriptions to *The Ohio State Medical Journal* and *The Journal of the AMA,* will expire on December 31, 1978. Here is how to renew:

Mail your dues promptly to the secretary-treasurer of your county society or to the OSMA if your county society uses the OSMA dues billing service.

★ Active Member	OSMA membership dues are $170; AMA dues are $250. (AMA dues $125 for physicians in first year of practice.) Contact the secretary-treasurer of your local society for correct amount of county dues.
★ Member-in-Training	OSMA dues are $20; AMA dues are $35. Membership entitles physician to all privileges including the right to vote and to hold office.
★ Student Member	OSMA dues are $15; AMA dues are $15. Full-time students enrolled in medical schools approved by the AMA are eligible.

OSMA members will receive *The Ohio State Medical Journal,* the *OSMAgram,* and *Synergy* without extra cost as part of the services and benefits of membership. AMA dues-paying members will receive a year's subscription to *The Journal of the AMA* and the *American Medical News.*

Any member who becomes eligible for exemption from dues because of retirement or disability should notify the secretary-treasurer of his county medical society to effect this status change.

For Futher Membership Information:

Contact— Mrs. Katherine E. Wisse, OSMA Comptroller, 600 S. High Street, Columbus, Ohio 43205, telephone: 614/228-6971.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg., Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

When impotence is due to androgenic deficiency.

Android® /5 mg. Buccal/ /10 mg. Oral /25 mg. Oral

Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric/eunuchoidism, eunuchism/post-puberal cryptorchidism.



Write for new double-blind study reprints and samples.

BROWN **THE BROWN PHARMACEUTICAL CO., INC.**
2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

THE OHIO STATE Medical Association

Letters to the Editor

To the Editor:

Enclosed you'll find a copy of the address remarks that my son, Fernando L. Yubero, a senior pre-medical student at Emory University, delivered at the end of the ceremonies celebrating his new citizenship.

At a time when few seem to appreciate it, we found Fernando's comments in that event particularly refreshing and inspiring. We'd like to share them with you and request its publication in your magazine, if you consider this appropriate.

/s/Gerardo Yubero, M.D.
Mansfield

Fernando L. Yubero's comments on October 13, 1978 were as follows:

Feelings of a New Citizen

Today officially, I became an American citizen. This is an honour upon a glory for me, and for my parents.

I say *officially,* because, in my heart and by my roots, I have always been an American. I was born in the place where America was born; in Seville, Spain, on the banks of the river, Guadalquivir, where Christopher Columbus, and his men set sail towards his Great Discovery, 488 years ago, yesterday, October 12.

There were three boats, whose names you may know: the Nina, the Pinta and the Santa Maria. They were filled with dreamers, like me, and all of you. *America,* if we believe America to be a dream, was born there.

There is a small monastery on the banks of that river, where Columbus and his sailors went to pray before beginning their Adventure. Today, it is a shrine . . . Contained therein, are twenty-one coffers with earth from the twenty-one independent republics of the Americas. Our beloved United States soil is among them . . .

This then, is my background, along with that of Ponce de Leon, the discoverer and explorer of Florida. Francisco de Coronado, the first European to see the vastness of the Canyon. The missionary priest, Father Serra of California, who made the first attempt to Christianize and to civilize the Indians. In so doing, he sprinkled the landscape of California with Spanish names: San Francisco, Santa Barbara, Los Angeles . . .

More recently, the name of Galvez is a part of our *mutual* heritage. Galvez was a faithful ally and General of the American Revolution. We won Alabama, Louisiana, and Mississippi for the United States, and defended them against further British attacks. Thus, Spanish blood, like mine, was also shed for the independence of this country.

I would like to add the name of Galvez, to those of the other well-known American patriots . . . Washington, Jefferson, Franklin, LaFayette, and Kosciusko. Because, my friends, that's what this country is made of: exceptional immigrants.

For me, and for all of you, wherever you may come from: Germany, Ireland, Italy, Greece, the Middle East, Africa or the Orient, I wish to say that we are Americans first, and that we should offer to this country the best of our roots, in our tradition, and the best of our future, in our effort.

With this Faith, all of us, together, old and new citizens, can make this country, once again: One Nation, *under God,* indivisible, with Liberty and Justice for all.

Watercolors of Columbus

PAINTINGS BY
OHIO PROFESSIONAL ARTISTS
CUSTOM FRAMING

Monday through Saturday
10 AM - 4 PM
917 East Granville Road
Shapter Center
(Route 161 and Busch Boulevard)
Columbus, Ohio 43229

Telephone: 614/888-0439

Rita V. Van Holte

Put a little art in your Christmas
May we suggest a gift certificate

easy to take







Keflex®
cephalexin

Lilly

Additional information available to the profession on request.
Eli Lilly and Company
Indianapolis, Indiana 46206

500738

THE OHIO STATE Medical Association Obituaries

NOLEN TOM BARNES, M.D., Toledo: Vanderbilt University School of Medicine, Nashville, 1927; age 77; died October 1; member OSMA and AMA.

LOUIS P. CASSADY, M.D., East Fultonham; Ohio State University College of Medicine, 1934; age 70; died October 1; member OSMA and AMA.

HENRY M. DUCKWALL, M.D., Dayton; St. Louis University School of Medicine, 1938; age 65; died October 17; member OSMA and AMA.

MURRAY GOODRICH, M.D., Metamora, Michigan; University of Michigan Medical School, Ann Arbor, 1926; age 80; died October 1; member OSMA and AMA.

GEORGE J. HEER, M.D., Columbus; Ohio State University College of Medicine, 1927; age 76; died October 21; member OSMA and AMA.

BERTHA M. JOSEPH, M.D., Martins Ferry; Woman's Medical College of Pennsylvania, Philadelphia, 1931; age 73; died October 5; member OSMA and AMA.

JOHN NORMAN McCANN, M.D., Youngstown; Georgetown University School of Medicine, Washington D.C., 1927; age 75; died October 4; member OSMA and AMA.

JOHN J. McCARTHY, M.D., Cleveland; University of Michigan Medical School, Ann Arbor, 1925; age 78; died October 4; member OSMA and AMA.

DONALD EDWARD MINCH, M.D., Cleveland; St. Louis University School of Medicine, 1946; age 56; died October 12; member OSMA and AMA.

DAVID MILTON POLOT, M.D., Cleveland; University of Louisville School of Medicine, 1935; age 74; died April 10; member OSMA and AMA.

R. ALAN WICKHAM, M.D., Dayton; St. Louis University School of Medicine, 1953; age 50; died October 13; member OSMA and AMA.

IN-HOME NURSING CARE

Recuperative Care
- Home Health Aides
- Live-ins

Skilled Care
- Registered Nurses
- Licensed Practical Nurses

Companionship
- Companions
- Live-ins

MEDICAL PERSONNEL POOL®

"A National Nursing Service"



- Qualified Personnel to Fit Your Schedule and Needs
- Screened — Bonded — Insured
- Under Registered Nurse Supervision
- 24-Hour Service

— *Five Ohio Offices* —

Columbus	Phone: 614/228-4456
Lancaster	Phone: 614/987-0954
Cincinnati	Phone: 513/221-0100
Dayton	Phone: 513/228-1000
Toledo	Phone: 419/473-1233

Angina freedom fighter...



Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Cardilate® (erythrityl tetranitrate)
INDICATIONS. For the prophylaxis and long-term treatment of patients with frequent or recurrent anginal pain and reduced exercise tolerance associated with angina pectoris, rather than for the treatment of the acute attack of angina pectoris, since its onset is somewhat slower than that of nitroglycerin.

PRECAUTIONS. As with other effective nitrites, some fall in blood pressure may occur with large doses.

Caution should be observed in administering the drug to patients with a history of recent cerebral hemorrhage, because of the vasodilation which occurs in the area. Although therapy permits more normal activity, the patient should not be allowed to misinteroret freedom from anginal attacks as a signal to drop all restrictions.

SIDE EFFECTS. No serious side effects have been reported. In sublingual therapy, a tingling sensation (like that of nitroglycerin) may sometimes be noted at the point of tablet contact with the mucous membrane. If objectionable, this may be mitigated by placing the tablet in the buccal pouch. As with nitroglycerin or other effective nitrates, temporary vascular headache may occur during the first few days of therapy. This can be controlled by temporary dosage reduction in order to allow adjustments of the cerebral hemodynamics to the initial marked cerebral vasodilation. These headaches usually disappear within one week of continuous therapy but may be minimized by the administration of analgesics.

Mild gastrointestinal disturbances occur occasionally with larger doses and may be controlled by reducing the dose temporarily.

DOSAGE: Therapy may be initiated with 10 mg sublingually prior to each anticipated physical or emotional stress and at bedtime for patients subject to nocturnal attacks. The dose may be increased or decreased as needed.

HOW SUPPLIED: 10 mg chewable scored tablets, bottle of 100. Also 5, 10 and 15 mg oral/sublingual scored tablets in bottles of 100. 10 mg oral/ sublingual scored tablets also supplied in bottle of 1,000.

Also available. Cardilate®-P (Erythrityl Tetranitrate with Phenobarbital)* Tablets (Scored).

(*Warning—may be habit-forming.)

1. Taken sublingually, Cardilate® (erythrityl tetranitrate) begins to work within 5 minutes, eliminating or reducing frequency and severity of anginal pain for up to two hours.
2. Fear of pain, a major deterrent to achieving acceptable (and desirable) levels of activity, including sex, may be allayed with Cardilate. Effective prophylaxis and improved exercise tolerance help toward normalizing the lives of anginal patients.

Cardilate®
(erythrityl tetranitrate)

OSMA Assists Physicians in Meeting the State Mandate

Carl E. Spragg, M.D., Chairman,
OSMA Committee on Education

DURING THE PAST FEW YEARS, continuing education has received much publicity and has generated a great deal of anxiety. Physicians are spending almost as much time talking about meeting the requirement for relicensure as they are about physician service review organizations (PSROs) or Medicaid. However, the continuing medical education (CME) requirement of the State of Ohio will make no change in the learning habits of the majority of Ohio physicians. Most physicians have been participating in CME for years without any pressure except their own desire to learn and to keep current in medical knowledge.

The confusion regarding continuing medical education stems from the separate requirements established by a number of agencies. It should be noted that the only legal mandate for CME is that of the State of Ohio (through Amended Substitute House Bill 682). The Ohio State Medical Board administers this requirement by using a modification of the CME plan accepted for the Physician Recognition Awards of the Ohio State Medical Association and the American Medical Association. The State program requires that a physician report 150 hours of continuing education to the Medical Board during the period January 1, 1977 through December 31, 1979. Of these 150 hours, a minimum of 60 must be earned in Category 1 courses.

Committee on Education

The Committee on Education of the Ohio State Medical Association is charged with two responsibilities. First, it must survey those Ohio institutions and organizations which wish accreditation to sponsor Category 1 education courses. Second, the Committee grants the OSMA Physician Recognition Awards.

During the process of accreditation, the Committee on Education provides an education and consultation service for directors of medical education, whether they are physicians or their nonphysician counterparts. Through workshops and individual consultation, the Committee acquaints them with the requirements for Category 1 courses and the efforts needed on the part of the sponsoring institutions.

Accreditation

To receive accreditation to sponsor Category 1 courses, an institution must be surveyed and approved by the Liaison Committee for Continuing Medical Education (LCCME). The LCCME has delegated the survey function to the OSMA Committee on Education for those institutions in Ohio other than schools of medicine.

When an application for Category 1 accreditation has been reviewed and the institution is considered ready for survey, a team of three physicians is selected. This team consists of an experienced surveyor and two other individuals who are, when feasible, a less-experienced surveyor and a member of the area's medical community but not necessarily of the institution's staff. The site visit is made during a scheduled education event, and the entire education activity is reviewed. The survey team reports to the OSMA Committee on Education, which forwards its recommendation to the LCCME for final determination.

The outcome of an initial survey may be one of the following: approval for four years, provisional approval for one or two years, or nonapproval. Another survey is scheduled at the end of the approval period. The survey team will concentrate on performance during the intervening period with emphasis on determination of need, objective, evaluation, and attendance records. Approval for four years, probation for a period of time, or nonapproval may be granted. All institutions receiving nonapproval or probation will receive a list of deficiencies and may reapply as soon as these are corrected.

Summary

Through its accreditation efforts, the OSMA Committee on Education aims at making quality education easily accessible to all Ohio physicians. With the accomplishment of this goal, Ohio physicians should have little trouble locating continuing education activities in order to meet the requirement for relicensure by the State of Ohio. ☆☆☆

Glory to the NEWBORN KING!

In the true spirit of Christmas, we wish you love, peace, and joy.



TURNER & SHEPARD, inc.

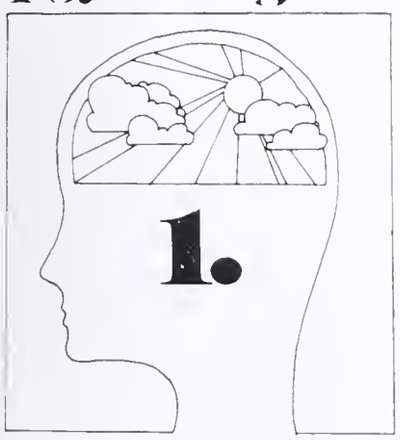
AFFILIATED WITH ALEXANDER & ALEXANDER, INC.

Columbus, Ohio 43215	17 South High Street	Phone (614) 228-6115
Akron, Ohio 44313	3090 West Market Street	Phone (216) 434-5000
Cincinnati, Ohio 45241	4015 Executive Park Drive	Phone (513) 563-4220
Cleveland, Ohio 44134	1440 Snow Road	Phone (216) 741-4466
Toledo, Ohio 43606	3450 West Central Avenue	Phone (419) 535-0616

A RATIONAL APPROACH TO WEIGHT CONTROL

Newly developed programs for the control of obesity rely on four principal factors, all of which must be integrated and individualized to fit the particualr case. These factors are psychological, dietetic, educational, & physical activity.

psychological



The WEIGHT WATCHERS organization is unique in that for over 15 years it has been using group interaction techniques to strengthen and maintain the motivation to lose excess body fat. Groups of overweight individuals are brought together under a trained leader for one or two hours a week. Motivation is strengthened by rewards for achievement, group discussion of individual eating problems and how to meet them and education in correct eating habits.

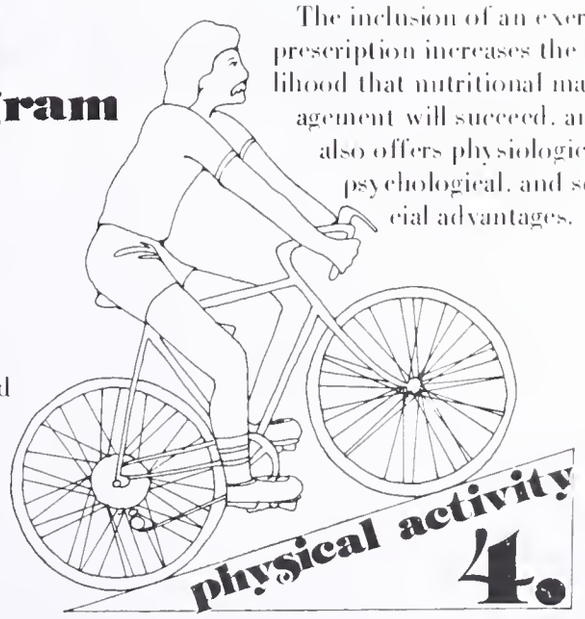
3. education

The third important factor in the control of obesity is the education of the patient in correct eating habits. But what are 'correct' eating habits? Very often the physician has not had enough training in nutrition to be able to provide the patient with accurate information.



2. food program

The WEIGHT WATCHERS eating plan is designed to produce a moderate weekly weight loss. It provides a proper intake of all vitamins, minerals and trace nutrients, and is designed to meet the nutritional needs of practically all normal individuals.



The inclusion of an exercise prescription increases the likelihood that nutritional management will succeed, and also offers physiological, psychological, and social advantages.

5. medical treatment

Handling obesity should be a team approach led by a physician who treats any complicating disease and decides that weight loss is indicated. He should then call on a paraprofessional group, like WEIGHT WATCHERS, trained in handling obesity to take care of the problems of diet and menu detail, and behavior modification, until the patient attains the desired weight and learns weight maintenance. The patient remains under the care of the physician for continued observation and treatment of any complicating disease, should it be present.

WEIGHT WATCHERS
of central Ohio
999 Bethel Road
Columbus, Ohio 43214
457-9080 toll free 1-800-282-8908

For further information, a pamphlet authored by Dr. William Sebrell, Medical Director of Weight Watchers International, is available to you upon request. Simply fill out & return coupon.

NAME_____

ADDRESS_____

CITY_____

STATE_____ ZIP_____

WEIGHT WATCHERS
The Authority.
Mona Adams, Area Director

"WEIGHT WATCHERS" IS THE REGISTERED TRADEMARK OF WEIGHT WATCHERS INTERNATIONAL, INC., MANHASSET, N.Y. ©WEIGHT WATCHERS INTERNATIONAL, 1978

January 1, 1977 - December 31, 1979

The Days of the First Triennial Registration of Ohio Medical Licenses

Linda A. Porterfield
Gail E. Dodson
David C. Torrens

IF YOU HOLD A LICENSE to practice medicine in Ohio, it will expire as of midnight, December 31, 1979. By that time, any physician who wishes to retain his/her license to practice medicine in the State of Ohio must have earned 150 hours of continuing medical education credit, and must have reported these hours to the Ohio State Medical Board.

By January 1, 1980, there will be no more time for compliance. Any physician who wishes to continue to practice medicine in Ohio during the period January 1, 1980 through December 31, 1982 must have conformed to the letter of the law.

Have you begun earning your continuing education hours? Have you completed the requirement? Do you understand fully the program and the necessity for conformance to it?

The dates are January 1, 1977 through December 31, 1979. The magic number is 150. The password is "log."

Background

During the summer of 1975, a most important piece of legislation was passed by the Ohio General Assembly. Amended Substitute House Bill 682, the Omnibus Medical Malpractice Act, covered many issues facing the medical community, including mandatory continuing education as a prerequisite for retention of medical licensure.

Specificially, Section 4731.281, Ohio Revised Code, requires that every physician desiring to practice medicine in Ohio must obtain a certificate of triennial registration from the Medical Board of the State of Ohio. In conjunction with the January 1980 registration and continuing every three years thereafter, a physician must present satisfactory evidence of completion of 150 hours of continuing medical education (CME) in order to be granted this certificate. These hours must be earned during the three years immediately preceding the beginning date of the license triennium.

Specifically, Section 4731.281, Ohio Revised Code, reads in part as follows:

> Every doctor of medicine licensed to practice medicine or surgery within this state shall, on or before the first day of January 1977, and on or before the first of January every third year thereafter, apply to the State Medical Board for a certificate of triennial registration with the Board upon an application which shall be furnished by the Board, and shall pay at such time a fee of $50 to the Board.
>
> With the January 1980 and all subsequent applications, the applicant shall include satisfactory evidence to the Board that in the preceding three years the practitioner had completed 150 hours of continuing medical education certified by the Ohio State Medical Association and approved by the Board. The applicant shall have been given sufficient choice of programs to assume that he has had a reasonable opportunity to participate in continuing medical education programs that are relevant to his medical practice in terms of subject matter and level.

Although this section of the Ohio Revised Code has engendered much controversy, the fact remains that the law requires continuing education and that there are no exceptions to the rule, including those physicians not working in the medical profession or those retired from the profession.

Since the Ohio State Medical Association has an obligation to assist member physicians in meeting the State requirement, this article is presented as an overview and review of the relicensure procedure.

Who Must Comply

There are no exceptions to the scope of Section 4731.281, Ohio Revised Code. Whether a physician has been in practice in Ohio since before the law's inception,

Mrs. Porterfield, Columbus, Executive Editor and Executive Business Manager, *The Ohio State Medical Journal.*
Mrs. Dodson, Columbus, Director, OSMA Department of Continuing Medical Education.
Mr. Torrens, Columbus, Assistant Director, OSMA Department of Continuing Medical Education.

has entered practice since 1976, or is retired, everyone desiring a license to practice medicine in Ohio after December 31, 1979 must comply with the statute. Even those individuals licensed in Ohio but practicing elsewhere must complete the required CME hours before the January 1980 registration.

Any physician who finds it impossible to complete the CME requirement—whether due to illness, military service, or location outside the United States—must send a letter to the Ohio State Medical Board. These letters, which should contain complete and detailed information, will be reviewed on a case-by-case basis.

The number of hours a physician must earn for relicensure is dependent upon when his/her current license was issued (Table). The maximum number of hours required is 150, divided such that no more than 90 hours may be earned in Category 2. The number of Category 1 hours must equal 60 as a minimum, but may exceed that number as desired.

Continuing education hours must be earned during the period January 1, 1977 through December 31, 1979. Hours earned before or after this period will not be accepted for reregistration of medical license on January 1, 1980. If a physician is licensed in Ohio during this triennium, hours of CME applicable to relicensure must be accrued after the date his/her license was issued but before January 1, 1980.

Categories of Credit

Continuing medical education courses acceptable for relicensure fall into two categories based upon those outlined in the American Medical Association and OSMA Physician Recognition Award programs. Category 1 of the mandatory CME program is identical to Category 1 of the programs of the AMA and OSMA. However, Categories 2 through 6 of the Associations' programs have been combined into one category under the mandatory program, Category 2.

The Ohio State Medical Board recognizes any Category 1 course sponsored by an organization or institution accredited by the Liaison Committee on Continuing Medical Education (LCCME). The sponsoring institution does not have to be based in Ohio nor does the course have to occur here. However, no provision exists for reciprocity of CME requirement for reregistration of medical license between the State of Ohio and other states.

In addition, accredited organizations may cosponsor activities of nonaccredited organizations provided the organization is actively involved in the planning, implementation, and evaluation of the program and accepts responsibility for the program's quality.

Individuals participating in internships, residencies, and fellowships may claim 50 hours of Category 1 credit for each full year of such training taken in a program that has been approved by the Liaison Committee on Graduate Medical Education. Study for a medically related degree also may be included. Full-time study for part of a year is accepted as one credit hour per week. Credits may not be claimed in any other category during a period of full-time training. All training must have occurred during the period January 1, 1977 to December 31, 1979.

Available Courses

Numerous organizations offer continuing medical education courses. When registering for a course, a physician should be aware whether that program meets the standards for Category 1 or Category 2 credit. The printed material regarding a Category 1 course should carry the following statement:

> "As an organization accredited for continuing medical education, (sponsoring organization) certifies that this continuing medical education offering meets the criteria for (number) hours in Category 1."

If a physician desires Category 1 credit and is not sure whether the sponsoring organization is accredited to present such programs, the physician should contact the department of continuing medical education of either the OSMA (for Ohio organizations) or the AMA (for organizations located outside Ohio).

Upon completion of a course, the physician should record the course in his/her "Log of Continuing Medical

TABLE. Requirements for Individuals Receiving Their Ohio License Interim Period Between Triennial Registrations

Period Within Which License Initially Received	Total Credits Required (Hrs.)	Minimum Category 1	Maximum Category 2
Jan. 1, 1977—Dec. 31, 1977	100	40	60
Jan. 1, 1978—Dec. 31, 1978	50	20	30
Jan. 1, 1979—Apr. 30, 1979	25	10	15
May 1, 1979—Dec. 31, 1979	0	0	0

Education Activities," and should obtain a statement of course completion from the sponsoring organization for his/her records.

One of the best sources of instate continuing medical education is the Annual Meeting of the Ohio State Medical Association. During the period of a Friday evening through a Wednesday afternoon, a physician can earn a wealth of hours in various education pursuits. A report on one such course offering appears in this issue. (See "Death and Dying" by Joan S. Fulton.)

The next OSMA Annual Meeting will be held May 12-16, 1979 in Columbus. For further information, read *The Journal* and/or contact the OSMA Department of Continuing Medical Education, 600 South High Street, Columbus 43215, telephone: 614/228-6971. In addition, through its Committee on Scientific Work, the OSMA sponsors many courses at times other than during Annual Meeting. The Department of Continuing Education can provide complete information.

Education meetings at Ohio hospitals are another source of local CME. *The Journal* carries a column, entitled "Continuing Education Programs," which lists those courses sponsored by Ohio-accredited organizations.

Also, a limited number of Category 1 hours may be earned by reading *The Ohio State Medical Journal*. Periodically, a scientific article is prepared that features a Category 1 examination which a physician may complete upon reading the article. (See Vol. 74, No. 11, November 1978, "Estrogen Therapy.")

In order to assist OSMA members in locating Ohio organizations accredited to present Category 1 continuing education courses, a list of those organizations accredited as of October 25, 1978 is printed herein.

Categories 1 and 2

Category 1 courses are those planned continuing education programs sponsored or cosponsored by an organization or institution accredited by the LCCME. Education courses that may be developed as Category 1 offerings include: grand or teaching rounds, department scientific meetings, seminars or workshops, clinical traineeships or mini-residencies, scientific sessions of medical societies, and visiting lecturer or professor programs.

Activities included in Category 2 are those with nonaccredited sponsorship as well as medical teaching, papers, publications, books, presentations, exhibits, nonsupervised individual CME activities, and other meritorious experiences. (Nonsupervised individual CME activities include self-instruction, consultation, patient-care review, self-assessment programs, and specialty board preparation.)

Additionally, use of audiovisual materials may be accredited for Category 1. If the audiovisual material is used as part of a Category 1 program, the time spent in its use should be included as part of the course. When a physician uses an audiovisual material on an individual basis, Category 1 credit may be claimed if the material is sponsored by an accredited organization, complies with the definition of a planned program of CME, and is evaluated by the sponsoring organization and the sponsoring organization has a method of documenting physician participation (ie, a recall examination, which is returned to the sponsor for scoring and as evidence of participation). There is a limit of 45 credit hours for use of audiovisual materials in Category 1.

Whether an activity is accredited for Category 1 or Category 2 credit, such credit is awarded on an hour-for-hour basis.

Evidence of Completion

A "Log of Continuing Medical Education Activities" has been developed to aid physicians in keeping account of their credit hours. (See pages 755 and 756.) Following completion of each course, a physician should note the appropriate information on the log. In addition, he/she should place documentation of completion of the course (ie, certificate, award, letter) in his/her personal records. This documentation should *not* be mailed to the Ohio State Medical Board with the log.

Once the physician has completed the required number of hours for reregistration of his license to practice medicine in Ohio, he/she should note all courses on the log, sign the document, and mail it to the Ohio State Medical Board. Send no money. However, it is suggested that the physician send the log via certified or registered mail, keeping a duplicate copy. Pages 753 and 754 of this issue contain a postal card the physician can stamp and enclose with his/her log in order to obtain verification that the Ohio State Medical Board did receive the log.

The Ohio State Medical Board also will accept one of the following items attached to the "Log of Continuing Medical Education Activities," in lieu of completing the course information on the log. However, all other information must be provided on the log including the signature.

1. An entire complete "Application for the American Medical Association Physician Recognition Award." The application must list the actual continuing medical education activities undertaken. These activities must have occurred within the period January 1, 1977 to December 31, 1979. (If the Physician's Recognition Award was earned for a time period other than that noted, only those courses participated in from January 1, 1977 to December 31, 1979 may be listed on the log.)
2. An entire completed "Application for the Ohio State Medical Association Physician Recognition Award." Again, the only applicable CME activities are those occurring between January 1, 1977 and December 31, 1979.
3. A computer listing from the American Academy of Family Physicians showing that the physician has met the Academy's continuing education requirements within the period January 1, 1977 to December 31, 1979.

Ohio Institutions Accredited to Present Category 1 Continuing Medical Education Courses

Akron City Hospital
525 E. Market St.
Akron 44204

Akron General Medical Center
400 Wabash Ave.
Akron 44307

American Broncho-Esophagological Association
2065 Adelbert Rd.
Cleveland 44106

American Electroencephalographic Society
36391 Maple Grove Rd.
Willoughby Hills 44094

Aultman Hospital
2600 Sixth St., N.W.
Canton 44710

Blanchard Valley Hospital
145 W. Wallace
Findlay 45840

Case Western Reserve University School of Medicine
2119 Abington Rd.
Cleveland 44106

The Children's Hospital of Akron
Buchtel Ave. at Bowery St.
Akron 44308

Children's Hospital
700 Children's Dr.
Columbus 43205

Children's Medical Center
1735 Valley St.
Dayton 45404

The Christ Hospital
2139 Auburn Ave.
Cincinnati 45219

University of Cincinnati
College of Medicine, Dean's Office
231 Bethesda Ave.
Cincinnati 45267

Cleveland Clinic Educational Foundation
9500 Euclid Ave.
Cleveland 44106

Community Medcenter Hospital
1040 Delaware Ave.
Marion 43302

Fort Steuben Foundation for Medical Education
c/o The Ohio Valley Hospital
380 Summit Ave.
Steubenville 43952

Good Samaritan Hospital
2222 Philadelphia Dr.
Dayton 45406

Greene Memorial Hospital, Inc.
Xenia 44385

Good Samaritan Hospital
Clifton and Dixmyth
Cincinnati 45220

Grant Hospital
309 E. State St.
Columbus 43215

Huron Road Hospital
13951 Terrace Rd.
Cleveland 44112

Hillcrest Hospital
6780 Mayfield Rd.
Mayfield Heights 44124

International Anesthesia Research Society
3645 Warrensville Center Rd.
Cleveland 44122

Kettering Medical Center
3535 Southern Blvd.
Kettering 45429

Lakewood Hospital
14519 Detroit Ave.
Lakewood 44107

Licking Memorial Hospital
1320 West Main St.
Newark 43055

Lutheran Medical Center
2609 Franklin Blvd.
Cleveland 44113

Mahoning Shenango Area Health Education Network
5211 Mahoning Ave.
Suite 310
Youngstown 44515

Medical College of Ohio
Caller Service No. 10008
Toledo 43699

Memorial Hospital of Union County
London Ave.
Marysville 43040

Mercy Medical Center
1343 Fountain Blvd.
Springfield 45501

Miami Valley Hospital
1 Wyoming St.
Dayton 45409

Mount Carmel Medical Center
793 West State St.
Columbus 43222

Nuclear Medicine Institute
6780 Mayfield Rd.
Cleveland 44124

Ohio Academy of Family Physicians
4075 North High St.
Columbus 43214

Ohio State University College of Medicine
Center for Continuing Medical Education
320 West Tenth Ave.
Columbus 43210

Ohio Thoracic Society
850 Michigan Ave.
Columbus 43215

Ohio Valley Society for Plastic and Reconstructive Surgery
405 E. Waldheim
Pittsburgh 15212

Riverside Methodist Hospital
3535 Olentangy River Rd.
Columbus 43214

Robinson Memorial Hospital
6847 N. Chestnut St.
Ravenna 44266

St. Anthony Hospital
1450 Hawthorne Ave.
Columbus 43203

St. Charles Hospital
2600 Navarre Ave.
Oregon 43616

St. Elizabeth Medical Center
601 Miami Blvd. W.
Dayton 45408

St. John Hospital
7911 Detroit Ave.
Cleveland 44102

St. Joseph Hospital
Community Hospital Consortium
205 W. 20th St.
Lorain 44052

St. Rita's Medical Center
730 W. Market St.
Lima 45801

St. Thomas Hospital
444 North Main St.
Akron 44310

Timken Mercy Hospital
2015 Twelfth St. N.W.
Canton 44708

Veterans Administration Center
4100 W. 3rd St.
Dayton 45428

Veterans Administration Hospital
Chillicothe 45601

USAF Medical Center
Wright-Patterson Air Force Base
45433

These institutions have been approved by the OSMA Committee on Education and are pending approval of the LCCME:

Bethesda Hospital
2951 Maple Ave.
Zanesville 43701

Community Hospital of Springfield and Clark County
2615 E. High
Springfield 45501

4. A transcript from the American College of Obstetricians and Gynecologists showing completion of the continuing professional development program within the period January 1, 1977 to December 31, 1979.

All logs (and attached material) will be reviewed by the Ohio State Medical Board. As there are some 26,000 plus Ohio medical licensees, this review will take some time. Any purposeful fraud gives the Board the right to take action against the physician in question. If a physician has any query as to whether an activity is acceptable under the Ohio State Medical Board program, he/she may wish to list hours in addition to those required for relicensure.

Upon completion of the requirement, the "Log of Continuing Medical Education Activities" (or log with one of the four additional items attached) should be submitted to:

The Ohio State Medical Board
Continuing Medical Education Log
180 East Broad Street, Suite 1006
Columbus, Ohio 43215

Due to the large number of persons licensed to practice medicine in the State of Ohio, both the Ohio State Medical Board and the Ohio State Medical Association urge physicians to submit their logs immediately following completion of the CME hours. The physician's medical education number (ME No.) can be found above his/her name on the OSMA membership card.

License Renewal

Ohio medical license renewal cards will be mailed by the Ohio State Medical Board during October 1979. These renewal cards will be for the triennium January 1, 1980 through December 31, 1982. If a physician has not received a renewal card by November 1, 1979, he/she should contact the Medical Board immediately.

License renewal is based upon a sworn statement that the physician must sign prior to returning his license renewal card. The statement on the renewal card will be similar to the following:

I certify, under the penalty of the loss of my right to practice medicine and surgery in the State of Ohio, that I have during the last triennium completed the requisite hours of continuing medical education certified by the Ohio State Medical Association or the Ohio Osteopathic Association and approved by the State Medical Board as prescribed herein, and have an accurate log indicating the dates, location, description of learning activity, sponsor, hours of study, and category which has been submitted to the Ohio State Medical Board.

A. 150 hours for those licensed before January 1, 1977.
B. 100 hours for those licensed between January 1, 1977 and December 31, 1977.
C. 50 hours for those licensed between January 1, 1978 and December 31, 1978.
D. 25 hours for those licensed between January 1, 1979 and April 30, 1979.
E. Zero hours for those licensed between May 1, 1979 and December 31, 1979.

The "Log of Continuing Medical Education Activities" should be sent prior to mailing the license renewal card. If the log has not been mailed, a physician should mail it *under separate cover* to the State Medical Board.

A $50 fee is required with the license renewal card. Checks should be made payable to the Treasurer of State.

Summary

Continuing medical education is required by Ohio statute in order for a physician to reregister his/her license to practice medicine on January 1, 1980. CME hours must be earned during the triennium period, January 1, 1977 through December 31, 1979 (or that portion of the period during which the physician held a license to practice medicine in Ohio).

Once a physician has completed the required continuing education hours, he/she should submit a "Log of Continuing Medical Education Activities" to the Ohio State Medical Board. A copy of the completed log and supporting evidence should be retained in the physician's records. No license renewal card should be mailed prior to mailing the log.

All logs must be mailed no later than December 31, 1979. However, due to the more than 26,000 licenses to practice medicine in Ohio that have been issued in this triennium, cooperation of physicians is asked in submitting logs as soon as the requirement is met.

Further information regarding this program is available from the Ohio State Medical Board or the OSMA Department of Continuing Medical Education. ☆☆☆

OSMA Members:

Use the following postal card and "Log of Continuing Medical Education Activities" when submitting your credit hours to the Ohio State Medical Board.

Tear and Use

Log of Continuing Medical Education Activities for the Period January 1, 1977 to December 31, 1979

CATEGORY 1: CME Activities with Accredited Sponsorship
At least *60* credits *must* be earned in this category
The total *150* credits *may* be earned in this category

(MUST BE PRINTED OR TYPED)

I CERTIFY THE FOLLOWING TO BE TRUE AND CORRECT FOR THE PERIOD JANUARY 1, 1977 to DECEMBER 31, 1979. This form must be completed, signed and returned for proper credit.

Signature: _____

Name: _____

Address _____

_____

_____

Social Security # _____

Ohio Cert. # _____

Medical Education # _____

Accredited Sponsor	Location of Activity City, State	Description of Activity	Date of Attendance From To	Credits

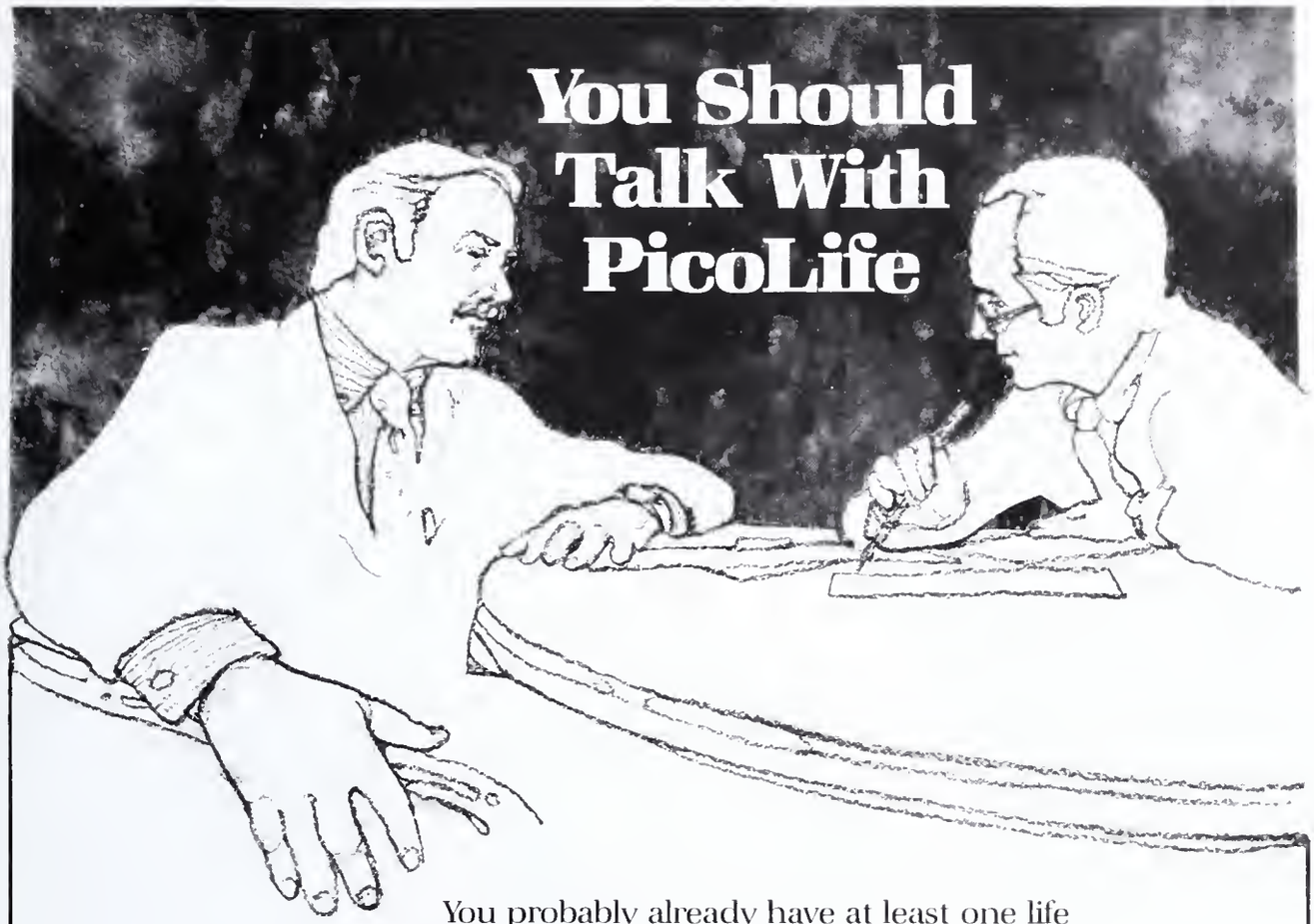
CATEGORY 2: CME Activities with Non-accredited Sponsorship; Medical Teaching; Papers, Publications, Books and Exhibits; Non-Supervised Individual CME Activities; and Other Meritorious Learning Experiences.

There is a *limit of 90 credits* for this category

(MUST BE PRINTED OR TYPED)

When Completed Return to:
Ohio State Medical Board
Continuing Medical Education Lo
180 East Broad Street
Suite 1006
Columbus, Ohio 43215

Sponsor: Institution, or Publication, or Physician, or Self	Location of Activity City, State	Description of Learning Activity (course, paper, journal name, etc.)	Dates of Activity From To	Credits



You probably already have at least one life insurance policy. Why talk with a Pico Life representative? Well, unless you're extremely well insured, you will be purchasing additional life insurance. You'll need more coverage to offset the effect of inflation on plans for your family's financial security, should something happen to you. You'll need more coverage to increase the level of guaranteed income during your slow down years. We have comprehensive, low cost plans to meet these objectives.

There's another reason we'd like to talk with you. As part of a physician controlled insurance organization, we have a special interest in your future. We'd like you to have an interest in ours. No stock purchase is necessary. All you do is purchase the life insurance you need.

When we call for an appointment, let's talk.

picolife

Pico Life Insurance Company
6100 Channingway Boulevard
Columbus, Ohio 43227
Telephone (614) 864-0280

A Subsidiary of Physicians Insurance Company of Ohio (PICO)

ANCEF®

brand of sterile

CEFAZOLIN SODIUM

GETS TO THE SITE



OF SERIOUS RESPIRATORY INFECTIONS

'Ancef' Penetrates Pleural Fluid

"...levels of cefazolin in pleural fluid...generally exceeded the median MICs of all organisms commonly associated with respiratory tract infections, with the exception of a small number of isolates of Klebsiella and H. influenzae.

—Cole, D.R., et al.: Antimicrob. Ag. Chemother. 11(6):1033-1035 (June) 1977.

Tissue penetration is essential to therapeutic efficacy; however, specific tissue levels have not been directly correlated with specific therapeutic results.

Before prescribing, see complete prescribing information in SK&F literature or PDR. The following is a brief summary.

Indications: Ancef® (sterile cefazolin sodium, SK&F) is indicated in the treatment of the following serious infections due to susceptible organisms:

Respiratory tract infections due to Streptococcus pneumoniae (formerly D. pneumoniae), Klebsiella species, Hemophilus influenzae, Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), and group A beta-hemolytic streptococci.

Injectable benzathine penicillin is considered to be the drug of choice in treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. 'Ancef' is effective in the eradication of streptococci from the nasopharynx; however, data establishing the efficacy of 'Ancef' in the subsequent prevention of rheumatic fever are not available at present.

Urinary tract infections due to Escherichia coli, Proteus mirabilis, Klebsiella species, and some strains of enterobacter and enterococci.

Skin structure infections due to Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), group A beta-hemolytic streptococci and other strains of streptococci.

Biliary tract infections due to Escherichia coli, various strains of streptococci, Proteus mirabilis, Klebsiella species and Staphylococcus aureus.

Bone and joint infections due to Staphylococcus aureus.

Genital infections (i.e., prostatitis, epididymitis) due to Escherichia coli, Proteus mirabilis, Klebsiella species, and some strains of enterococci.

Septicemia due to Streptococcus pneumoniae (formerly D. pneumoniae), Staphylococcus aureus (penicillin-sensitive and penicillin-resistant), Proteus mirabilis, Escherichia coli, and Klebsiella species.

Endocarditis due to Staphylococcus aureus (penicillin-sensitive and penicillin-resistant) and group A beta-hemolytic streptococci.

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to 'Ancef'.

Contraindications: ANCEF (STERILE CEFAZOLIN SODIUM, SK&F) IS CONTRAINDICATED IN PATIENTS WITH KNOWN ALLERGY TO THE CEPHALOSPORIN GROUP OF ANTIBIOTICS.

Warnings: BEFORE CEFAZOLIN THERAPY IS INSTITUTED, CAREFUL INQUIRY SHOULD BE MADE CONCERNING PREVIOUS HYPERSENSITIVITY REACTIONS TO CEPHALOSPORINS AND PENICILLIN. CEPHALOSPORIN C DERIVATIVES SHOULD BE GIVEN CAUTIOUSLY IN PENICILLIN-SENSITIVE PATIENTS.

SERIOUS ACUTE HYPERSENSITIVITY REACTIONS MAY REQUIRE EPINEPHRINE AND OTHER EMERGENCY MEASURES.

There is some clinical and laboratory evidence of partial cross-allergenicity of the penicillins and the cephalosporins. Patients have been reported to have had severe reactions (including anaphylaxis) to both drugs.

Any patient who has demonstrated some form of allergy, particularly to drugs, should receive antibiotics cautiously. No exception should be made with regard to 'Ancef'.

Usage in Pregnancy: Safety of this product for use during pregnancy has not been established

Usage in Infants: Safety for use in prematures and infants under 1 month of age has not been established.

Precautions: Prolonged use of 'Ancef' may result in the overgrowth of nonsusceptible organisms. Careful clinical observation of the patient is essential.

When 'Ancef' is administered to patients with low urinary output because of impaired renal function, lower daily dosage is required (see dosage instructions). A false positive reaction for glucose in the urine of patients on 'Ancef' has occurred with Clinitest® tablets solution.

Adverse Reactions: The following reactions have been reported. **Hypersensitivity:** Drug fever, skin rash, vulvar pruritus, and eosinophilia have occurred. **Blood:** Neutropenia, leukopenia, thrombocythemia and positive direct and indirect Coombs tests have occurred. **Hepatic and Renal:** Transient rise in SGOT, SGPT, BUN and alkaline phosphatase levels has been observed without clinical evidence of renal or hepatic impairment. **Gastrointestinal:** Nausea, anorexia, vomiting, diarrhea, oral candidiasis (oral thrush) have been reported **Other:** Pain at site of injection after intramuscular administration has occurred, some with induration. Phlebitis at site of injection has been noted. Other reactions have included genital and anal pruritus, genital moniliasis, and vaginitis.

How Supplied: Ancef® (sterile cefazolin sodium, SK&F)—supplied in vials equivalent to 250 mg., 500 mg., or 1 gram of cefazolin; in "Piggyback" Vials for intravenous admixture equivalent to 500 mg. or 1 gram of cefazolin; and in Pharmacy Bulk Vials equivalent to 5 grams or 10 grams of cefazolin.

ANCEF® IV IM

brand of sterile

CEFAZOLIN SODIUM

(LYOPHILIZED)

Injection: 250 mg., 500 mg. and 1 gram vials

Smith Kline & French Laboratories
Philadelphia, Pa.

SK&F
a SmithKline company



1979 Annual Meeting, Ohio State Medical Association

DO YOU HAVE AN EXHIBIT or know of an exhibit which is of scientific interest? If you do, the Ohio State Medical Association Annual Meeting is just the place to display it. We are now accepting applications for the 1979 OSMA Annual Meeting. Those eligible to apply are as follows: (1) Exhibits by Ohio physicians, Ohio medical schools, hospitals, or similiar organizations; (2) Out-of-state physicians or out-of-state agencies on invitation; (3) Voluntary health organizations.

Exhibits will be set up and viewed at the Veterans Memorial Building, 300 West Broad Street, Columbus, Ohio. Exhibit Days and Times will be as follows: Monday, May 14 — 12 NOON - 4:30 PM; Tuesday, May 15 — 9 AM - 4:30 PM; and Wednesday, May 16 — 9 AM - 12 NOON.

Mail applications to the attention of Vincent T. La Maida, M.D., Chairman, Subcommittee on Scientific Exhibits, Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215.

APPLICATION FOR SPACE
SCIENTIFIC EXHIBITS

1979 Annual Meeting, Ohio State Medical Association

Veterans Memorial Building, Columbus, May 14, 15, and 16

___I am interested in receiving an application and details regarding space for a scientific exhibit at the 1979 OSMA Annual Meeting. Please send to:

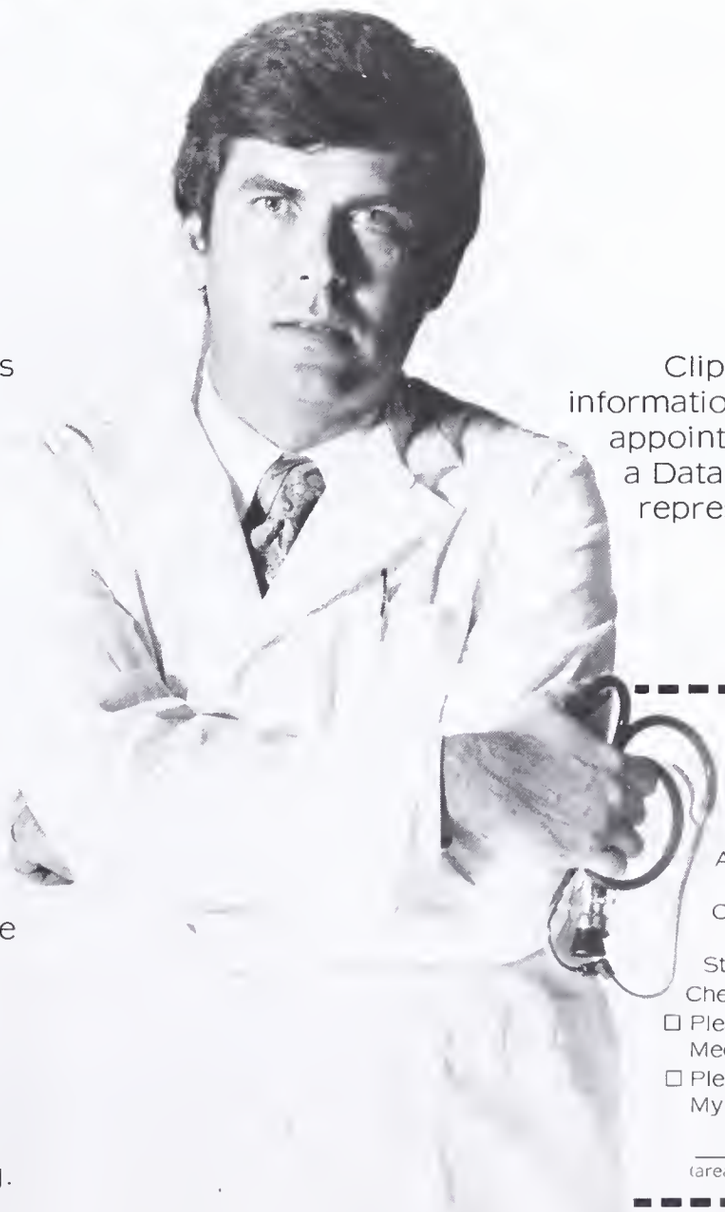
Name_____

Address_____

City_____ State_____ Zip_____

Medical Data-Plan®

We're not offering you just a computerized billing system. We're offering you a way to plan the future of your practice.



Medical Data-Plan is a computerized system for getting bills out, processing insurance forms, speeding up cash flow and improving collections.

It also gives you the information you need to plan the future of your practice . . . 3 years, 5 years, 10 years from now.

Based on a steady flow of accurate, timely computer reports, your business manager can make sound recommendations on personnel, equipment, materials, facilities and more. Medical Data-Plan can show you what your practice has been doing—and what it should be doing.

Clip this coupon to receive information or to arrange an appointment with a Data-Plan representative.

Data-Plan

Medical Data-Plan OM 8
Box 7947, Madison, Wisconsin 53707

Name _____

Address _____

City _____

State _____ Zip _____

Check one or both boxes below:

☐ Please mail me more information about Medical Data-Plan.

☐ Please have a representative contact me. My phone number is:

_____
(area code) (number)

Medical Data-Plan, Box 7947, Madison, Wisconsin 53707

Frequent Questions Regarding Mandatory Continuing Education

Can I continue to practice medicine in Ohio after December 31, 1979 if I have not earned and certified to the Ohio State Medical Board the required number of hours of continuing medical education?

No.

Which physicians must participate in the continuing education program mandated by the State of Ohio?

Any physician who is licensed to practice medicine in Ohio during the period January 1, 1977 through December 31, 1979 and who intends to continue to practice in the State or to maintain his/her Ohio license after December 31, 1979.

I am retired. Can I be excused from the requirement?

Not if you wish to retain your license to practice medicine in Ohio. There are no exceptions to the scope of the law. However, retired physicians do not need to maintain their Ohio licenses in order to hold membership in the OSMA.

I have been ill and will be unable to complete the continuing education hours by December 31, 1979. What do I do?

Any physician unable to comply with the requirement— for whatever reason— should send a letter to the Ohio State Medical Board giving all pertinent information. Each instance will be considered individually.

I have had a license to practice medicine in Ohio since January 1, 1977. How many hours of continuing education must I earn?

A minimum of 150 hours divided so that at least 60 hours fall in Category 1 and no more than 90 hours fall into Category 2.

I have not been practicing in Ohio since January 1, 1977. How many hours do I need?

The number of continuing education hours is dependant upon when a physician's Ohio Medical license was issued.

I earned 100 hours of continuing medical education during the triennium but before I received my Ohio license. Do these count toward my state requirement?

No. Only those hours earned after a physician receives his license to practice medicine in Ohio can be applied to the relicensure requirement.

I practice in another state, but I want to retain my Ohio license. Will completion of that state's relicensure requirement renew my Ohio license?

No. There is no provision for reciprocity of continuing education requirement between the State of Ohio and other states.

I received a Physician's Recognition Award, but it does not cover the same period as the relicensure triennium. May I use it to renew my license?

Only those hours earned during the triennium— January 1, 1977 through December 31, 1979— are applicable to meet the requirement of the State of Ohio. These hours should be noted on your "Log of Continuing Medical Education Activities," but the entire Physician's Recognition Award course listing cannot be used as the basis for relicensure.

How do I know if a course is approved for Category 1 credit?

The printed material describing the course should carry a notation to that effect. Verify this with the sponsoring organization.

May I participate in courses sponsored by non-Ohio organizations or held outside the border of the State of Ohio?

Yes. The Ohio State Medical Board recognizes any Category 1 course sponsored by an organization or institution accredited by the Liaison Committee on Continuing Medical Education.

I cannot get away from my practice very much. How do I earn hours at home?

Category 1 hours can be earned at regional continuing medical education courses, through your hospital staff meetings, and by reading The Ohio State Medical Journal. (See Vol. 74, No. 11, November 1978.) Category 2 hours are available for such activities as reading medical publications, writing articles, and completing self-assessment projects.

Do I need to keep a record of what courses I attend?

Yes. The "Log of Continuing Medical Education Activities" was designed so that physicians can record participation in courses and activities. Fill in the appropriate information following each education activity. Also, place in your files any other documentation of the activity. Be sure to retain a copy of your log when you mail it to the Ohio State Medical Board.

Where do I obtain a log?

Logs are available from the Ohio State Medical Board and the OSMA Department of Continuing Medical Education.

There is a space for my medical education number on the log. What is this number?

This is a number that was assigned to you while in medical school. It is listed above your name on your OSMA membership card and also on your AMA membership card.

Must I sign the log?

Yes.

Where do I send my completed log?

Send your log to: The Ohio State Medical Board, Continuing Medical Education Log, 180 East Broad Street, Suite 1006, Columbus, Ohio 43215. Do not send it to the OSMA.

Should I return my log and my medical license renewal card to the Medical Board at the same time?

No. Logs should be mailed before license renewal cards. In fact, due to the thousands of licenses to practice medicine that have been issued in Ohio this triennium, the Medical Board asks that physicians mail their logs as soon as they have completed the continuing education requirement.

Do I send any money with my log?

No. Send an appropriate check with your license renewal card only.

I just mailed all the journals I read to the Medical Board as evidence of completion of certain credit hours. Is that correct?

No, do not mail anything to the Ohio State Medical Board except a completed and signed copy of your log. If applicable, attach to it the application form for either the OSMA or AMA Physician's Recognition Award, a computer listing from the American Academy of Family Physicians, or a transcript from the American College of Obstetricians and Gynecologists.

How will I know my log was received by the Ohio State Medical Board?

Mail it by registered mail. Also, this issue of The Journal contains a postal card that you can complete and enclose with your log. The Medical Board will stamp the card indicating the date of arrival of your log.

How will the Medical Board know if all courses listed on the logs are legitimate?

The Medical Board will spot-check logs. In addition, a medical license for the period January 1, 1980 through December 31, 1982 will be issued on the basis of a sworn statement made by the physician to the effect that he/she has complied with the law.

When will the medical license renewal cards be mailed?

The renewal cards will be mailed during October 1979. Contact the Medical Board if you have not received a card by November 1, 1979. ☆☆☆

Make your beeper cheaper.



The Code-A-Phone® answering system can cut the costs of your electronic pager.

With a fully automatic answering system that includes the 555, you can eliminate answering services. And the high costs that go with them.

Your phone is answered, incoming messages are recorded, and you are paged. All automatically.

Stop in and see the Code-A-Phone 555 for yourself. We'll show you how it can make answering your phone cheaper. Not steeper.

CODE-A-PHONE®

Your Ohio Code-A-Phone Dealers

APOLLO COMMUNICATIONS
1143 Canton Road
Akron 44312
Phone: 216/794-9494

RACOM, INC.
5504 State Road
Cleveland 44134
Phone: 216/351-0077

ADVANCED BUSINESS COMMUNICATIONS
1200 W. Third Avenue
Columbus 43212
Phone: 614/299-4960

DIMENSION ELECTRONICS
1619 Mardon Drive
Dayton 45432
Phone: 513/426-9520

TEL-MATIC SYSTEMS
1712 Jefferson Avenue
Toledo 43624
Phone: 419/241-8141

RADI-O-SOUND COMMUNICATIONS CO.
2110 South Avenue
P.O. Box 2612 South
Youngstown 44507
Phone: 216/746-1450

Code-A-Phone is a registered trademark of Ford Industries, Inc.



Tolinase®
tolazamide, Upjohn

Please contact your Upjohn representative for additional product information.

Upjohn

J-5695-6

©1977 THE UPJOHN COMPANY

Continuing Medical Education for Osteopathic Physicians

Evelyn L. Cover, D.O.

THE CONCEPT OF MANDATORY continuing medical education (CME) is not new to the osteopathic medical profession. As early as 1943, the Ohio Osteopathic Association supported and implemented legislation that required "at least two days of annual education programs conducted by the Ohio Osteopathic Association." These original requirements were outlined in the Ohio Revised Code and remained in effect until CME requirements for all physicians were revised in 1975 through Amended Substitute House Bill 682. It is important to note that the original provision applied to all osteopathic physicians licensed in Ohio, whether they were members of the state association or not.

As the national certifying organization for the osteopathic profession, the American Osteopathic Association (AOA) has constantly revised and developed national policies concerning continuing medical education. In 1972, three years before the 150-hour requirement was mandated by State of Ohio law, the American Osteopathic Association adopted a mandatory, 150-hour, three-year CME program as a condition of membership in the national and state associations.

Committee on Continuing Medical Education

The AOA Board of Trustees established the Committee on Continuing Medical Education in January 1973 to direct AOA programs of continuing medical education. The Committee is composed of one representative respectively from the Association of Osteopathic State Executive Directors, the AOA practice organization affiliates, the American Association of Colleges of Osteopathic Medicine, and the Academy of Osteopathic Directors of Medical Education; two members from the AOA House of Delegates; and the chairman, who is appointed by the AOA president. Donald Siehl, D.O., Dayton, was appointed the first chairman of the Committee and was instrumental in developing the national program, which also was adopted by the state association.

The primary goal of the Committee is to improve the quality of osteopathic medical care by helping to assure that osteopathic physicians are aware of advances in medical knowledge. The Committee assists providers of osteopathic CME in coordinating activities throughout the profession. In addition, the Committee has the authority to approve decisions affecting the entire program, and it implements continuing medical education policy by establishing flexible regulations and guidelines through which AOA members may fulfill the CME requirement.

The AOA Board of Trustees has granted the Committee broad discretionary powers to make individual decisions within the general guidelines of the continuing medical education program. For example, the Committee may waive or reduce the requirements for AOA members with extenuating circumstances. This same discretionary power has been granted to the Ohio Osteopathic Association's Committee on Professional Affairs, which monitors the program at the state level.

Continuing Education Program

The initial three-year period of the AOA continuing medical education program was from June 1, 1973 through December 21, 1976. The AOA program is fully computerized, and each physician's record is carefully reviewed for mandatory compliance. At the end of the first three-year program, nearly 200 doctors of osteopathy were dropped from AOA membership for failing to comply with the mandatory CME requirements, demonstrating the profession's total commitment to the CME concept.

The American Osteopathic Association has published a "CME Guide" for osteopaths, which outlines specific details of the program. Not only does the AOA specify the total number of hours, but it also requires that at least 60

Dr. Cover, Columbus, member OSMA Committee on Education, Ohio State Medical Board, and Ohio Osteopathic Association; Attending Staff, Doctors Hospitals North and West, Columbus; and Clinical Faculty, Ohio University College of Osteopathic Medicine, Athens.

Submitted October 12, 1978.

hours must be completed in what is termed Category 1—Osteopathic CME. This program was approved for osteopathic physicians by the Ohio State Medical Board in January of 1977.

"For Category 1, you must have an osteopathic sponsor and 50% osteopathic faculty which can include DOs and Ph.Ds from one of the approved osteopathic colleges," explains Dr. Siehl, current AOA President. "The rest of the requirement can be earned in Category 2, which basically includes those CME activities which are sponsored by nonosteopathic institutions."

Within the present CME framework, the AOA increasingly has been concerned with improvement of the entire program. In January 1978, the AOA Board of Trustees adopted a report from the Committee on Continuing Medical Education setting up guidelines to meet this goal. The guidelines stress assisting various groups set up quality programs, developing quality standards, and encouraging various osteopathic organizations to work together to achieve this goal.

Reports of CME activities may be submitted to the Division of Continuing Medical Education by either sponsors or individual physicians. However, it is mandatory that each report of CME activities be submitted on the appropriate form. The AOA will maintain computerized records for members and nonmembers alike: however, a fee is charged to osteopaths who are not members of the Association. Sponsors of formal Category 1-A programs are required to report physician participation on an official "Roster of Attendance." This form is used to document attendance at formal education programs sponsored by recognized organizations and institutions. It is the responsibility of these sponsors to inform physicians attending a program that their names are being submitted on the appropriate form.

The Committee on Continuing Medical Education reserves the right to evaluate all programs and activities on an individual basis and to deny CME credits at its discretion to those activities that do not fulfill criteria described in the official "CME Guide." For most continuing medical education programs, credit is granted on the formula of one credit for each hour of education activity. That formula may be modified at the Committee's discretion, depending on individual circumstances. However, in no case is CME credit granted for coffee breaks, social functions, or time allotted to business or administrative matters.

Reports of CME activities which meet criteria will be accepted, and appropriate credits will be entered on the physician's record. All credits are reported periodically to the individual physician on a computerized "Individual Activity Report."

Summary

In conclusion, the American Osteopathic Association Continuing Medical Education Program is mandatory, fully computerized, and tested. The program is believed to be the first mandatory CME program implemented by a national medical association with the possible exception of the American Academy of Family Practice. It has proved to be flexible, is carefully monitored for compliance, and continually is being refined to meet the postgraduate education needs of osteopathic physicians.

☆☆☆

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

OHIO OFFICES:

CINCINNATI: Room 700, 3333 Vine Street, (513) 751-0657, L. A. Flaherty

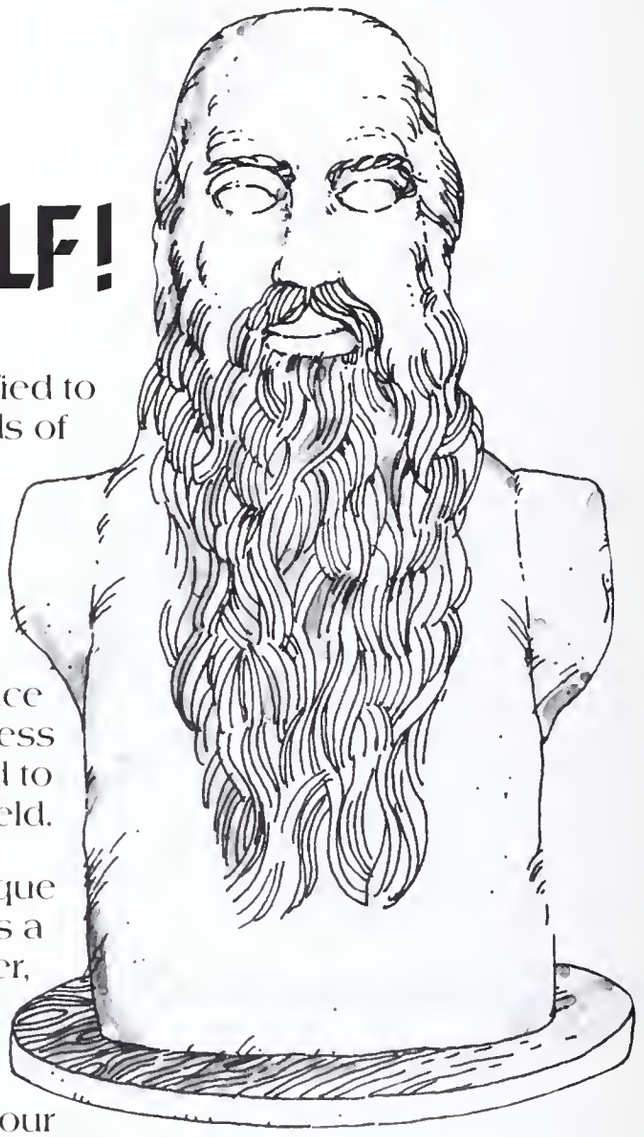
CLEVELAND: Suite 106, 23360 Chagrin Boulevard, Beachwood 44122, (216) 464-9950

A. C. Spoth, Jr., R. A. Zimmerman

COLUMBUS: 1989 West 5th Ave., (614) 486-3939, J. E. Hansel

TOLEDO: 1011 Sandusky St., Suite H, P.O. Box 331, Perrysburg 43551, (419) 874-8080, R. E. Stallter

PHYSICIAN, INSURE THYSELF!



Who could be better qualified to meet the insurance needs of physicians than an insurance company owned by physicians?

PICO offers the financial stability of a legal reserve insurance company, the expertise of professional insurance management, the aggressiveness of a company determined to outperform others in its field.

With PICO you have a unique opportunity to benefit, as a policyholder and stockholder, from the strengths of a growing insurance organization.

Socrates wouldn't mind our paraphrase of his wise admonishment, "Physicians Heal Thyself." We've just adapted it to a current need.

PICO

Formed by physicians, to serve physicians.

Physicians Insurance Company of Ohio
6100 Channingway Boulevard
Columbus, Ohio 43227

For the name of PICO's authorized agency in your area, telephone toll free 1-800-282-7515

Complete Protection for Your Medical Practice, Homes, Cars, and Other Possessions

Death and Dying

Joan S. Fulton

Editor's Note: *One way to earn continuing medical education (CME) hours is to participate in courses sponsored by the Ohio State Medical Association. These courses are accredited for Category 1, which signifies rigorous planning and depth of course content. Offered through the OSMA Department of Continuing Medical Education, the numerous courses include those held in conjunction with the Annual Meeting. One such course was that entitled "Death and Dying," which is herein described.*—**L.A.P.**

SENSITIVITY and EFFECTIVE communication, the two most important qualities needed to help the dying patient and the grief-stricken, are often the least demonstrated by physicians, according to Roger D. Blackwell, Ph.D., Professor of Administrative Science, The Ohio State University.

Dr. Blackwell, who conducted the continuing medical education course "Death and Dying" at the Ohio State Medical Association 1978 Annual Meeting, does not believe that physicians are uncaring about dying patients and their survivors.

"Attending physicians are so involved in coping with the problems of sickness and the preservation of life that they are not necessarily geared to coming to grips with death on a deep and serious level," Blackwell said.

Changing attitudes toward death and dying require physicians to expand their talents toward meeting the needs of dying patients and their survivors.

"Most people want physicians to tell them if they have a terminal illness. I believe that physicians ought to give honest, complete, and up-to-date information but with a note of compassion," Blackwell stated.

He stressed the importance of getting individuals to talk about death with those who are close to them.

"I hope that you are doing this with your own patients to help them understand that it is not healthy to ignore or not talk about death. If you have a sense of vulnerability, you have a taste of the dying experience."

Stages of Dying

Physicians can aid their dying patients by recognizing and helping their progression through the five stages of dying as outlined by Dr. Elisabeth Kubler-Ross, recognized authority on death literature.

Denial.— Patient avoids reality of what is inevitable.

Anger.— Patient can no longer deny reality.

Bargaining.— Patient promises physician or God "If you will just give me three months more."

Depression.— Patient should be allowed to experience it as a normal reaction.

Acceptance.— Patient is **prepared** to die— not happy to die— but ready to accept it.

The desire for death with dignity when there is no hope for recovery is causing individuals to elect not to die in hospitals. Death with dignity has popularized the hospice concept where emphasis is placed on relieving pain and on interaction with other people and family to whatever degree the patient can handle.

Children and Death

When explaining death to children, Blackwell says, "You must be specific about 'dead' and not make up fairy tales. Urban children do not have as many life-and-death experiences as farm children, so it is important to teach children about death when the opportunity arises.

"Use experiences of bird or pet deaths to come to grips with the problem at that point so that when Grandpa or another family member dies, the child has some frame of reference.

"Teaching children about death when Grandfather dies makes about as much sense as teaching children about sex when the teenage daughter comes home and says, 'I'm going to have a baby.' "

He highly recommends the book by Grollman, *Explaining Death to Children,* as a "classic aid" in teaching children about death.

Mrs. Fulton, Columbus, is a free lance writer and editorial assistant, Tri-Village Publishing Company; free lance public relations project coordinator; and wife of Richard L. Fulton, M.D., OSMA Past President and AMA Alternate Delegate from Ohio.

Submitted July 15, 1978.

Suicide

Blackwell believes that the need to talk and to work with attempted-suicide victims is especially important. The suicide rate among the young has risen three times faster in the last 20 years than in the previous 20 years. The most frequent motivation for suicide is a feeling of helplessness— of not being able to cope with situations and problems.

Paradoxically, physicians, who are dedicated professionally to the preservation of life, lead the list of all professionals who commit suicide. Blackwell attributes this to the stresses of the profession and to recognizing incurable disease in oneself.

Survivors

"Death causes problems for the ones who are left. It is primarily a woman's problem. If you are a woman and choose to be married, you are in effect choosing to be a widow," Blackwell states.

Reported incidence of illness requiring medical treatment is about three times as high for widows in the same general age and medical categories as nonwidows. Research shows that the more change in an individual's life, the more likely the person is to have physical problems in the period immediately following the change.

When trying to meet the needs of the grief stricken, it is important for physicians to advise patients not to make any major or irrevocable changes for at least a year following the death unless the change is absolutely necessary.

Grief

Sudden deaths, mass deaths, gruesome deaths, and deaths of young people are the most intense, grief-producing types of death and need the most extensive treatment of grief. We grieve because we love. As the love relationship develops, the more intense the grief is when a loss is suffered. Denial of death in a strong love relationship can create serious problems, and resolution of the denial should be encouraged.

Coping with grief or "grief work" can be done only by the individual. The sensitive physician can aid a patient in doing this work. One way in which the physician can help is by recognizing and dealing with the four types of grief. Blackwell lists these as philosophical, social, physical, and psychological. He says that one of the reasons that human beings have problems dealing with grief is that they do not recognize the types of grief.

Ministers basically deal with philosophical grief— "It was God's will" or "He's no longer suffering." Physicians and educators need to help the patient deal with the other three types of grief.

Social Grief.— Where the survivor, usually a widow, is socially isolated in a coupled society. Problems of upper-middle-class women are more severe than lower-middle-class women.

Physical Grief.— Actual work loss. "Who will shovel snow, mow the lawn, share the physical demands of keeping a home?"

Psychological Grief.— Feeling sorry for self, lonely, alone, feelings of separation and loss.

Blackwell believes that more structures for single-person involvement in the community are needed. These would be helpful particularly in dealing with social and psychological grief.

When grief occurs, a great surge of energy (grief energy) develops and should be discharged in some way. Blackwell says that one of the best elements for discharging grief energy is to confront the physical body.

"Confrontation with the dead body in supportive surroundings, perhaps with just family present, is the very best outlet for grief energy," he states.

Guilt

The grief stricken are beset with three levels of guilt: survivor guilt, imaginary guilt, and real guilt. Here again, talking and listening (communication and sensitivity) help the most.

Survivor Guilt.— Patient feels guilty about being the survivor. Help patient talk about those feelings. Explain that death occurs to everything and that the timing of it is chance.

Imaginary Guilt.— Patient feels responsible for other person's death. Again, talking and listening are important. Repeat belief that death is a chance experience.

Real Guilt.— Patient is actually responsible for death of another such as in reckless driving. Here restitution can be helpful: a "therapeutic sentence" such as working in a driver's education course.

In all cases, the grieving person must be able to talk about grief feelings with someone who knows how to listen. The listener should be able to feed back what the person is saying. Hearing one's locked up thoughts spoken aloud by a sensitive listener is tremendously beneficial. With imaginary guilt, it may be necessary to reenact the situation to relieve the guilt. Always try to find out where the person is vulnerable. Do not assume that everyone will react in the same manner to the same experience.

When is grief work done? "Not as soon as one may think," Blackwell says. Grievers should not be rushed through this period. He suggests that patients should be told not to worry about how long grief feelings last unless the patients are immobilized by those feelings.

According to Blackwell, sound grief procedures are: (1) when a person experiences daily a full range of emotions— everything is not sad; (2) when one can remember and talk about the dead person without pain most of the time; and (3) when one can look on the loss with some understanding that allows the individual to face additional losses.

Summary

"Interest in death and dying is mushrooming and particularly among young people because they have been removed from the dying experience," Blackwell notes.

"This is the first generation where middle-age children are burying their parents."

In the past, people died at home and at earlier ages. Today approximately 80% of all deaths occur in institutions where young people are often not allowed to visit. Quite naturally, individuals and communities turn to their physicians for information and counseling on death, dying, and grief management.

Excellent resources are available for programs or for individual study on death and dying. Logos Bookstore, Columbus, has a most comprehensive collection of death literature. Excellent films and the equipment to show them are available from the Ohio Funeral Directors Association. Of the hundreds of pieces of death literature available, Blackwell mentioned a few that he calls "classic." They are *Care for the Dying* by Soulen, *The Dying Patient* by Caughill, *A Grief Observed* by Lewis, and *You and Your Grief* by Jackson. ☆☆☆



WINDSOR HOSPITAL
A NONPROFIT CORPORATION
— ESTABLISHED 1898 —
Chagrin Falls, Ohio
247 - 5300
A hospital for the treatment of Psychiatric Disorders
High on a Hill-Top, Overlooking Beautiful Chagrin River Valley.
Accredited by Joint Commission on Accreditation of Hospitals.
Booklet available on request.
FRIEDRICH A. LINGL, M.D. Medical Director
GUY H. WILLIAMS, JR., M.D. Medical Director Emeritus
HERBERT A. SIHLER Jr. President
MEMBER: American Hospital Association—National Association of Private Psychiatric Hospitals

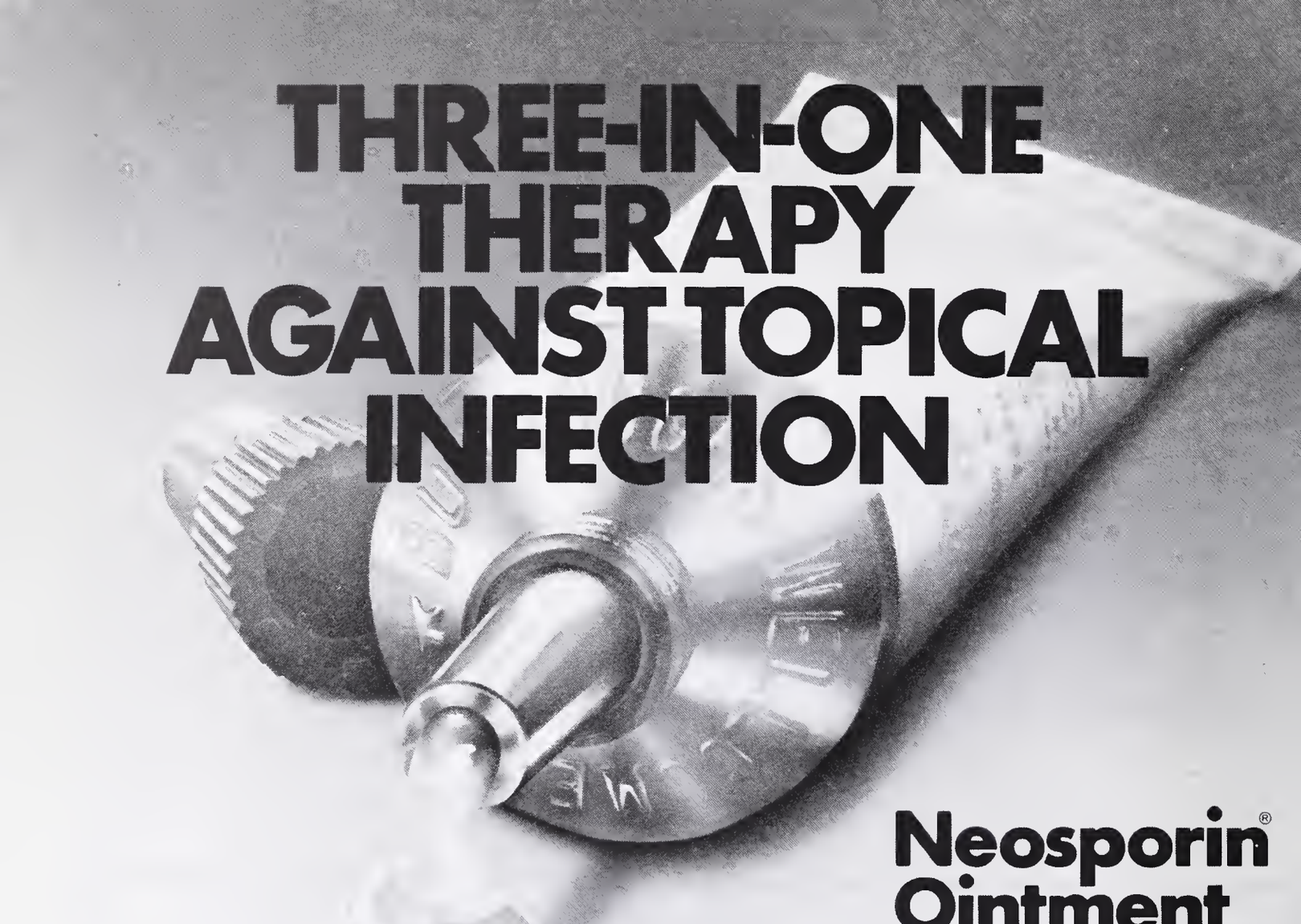
When You Lease a Car or Truck at Bobb Chevrolet
We're With You All The Way



With a Bobb lease you can: • Get any make or model you choose • Have a professional do your car or truck shopping for you • Eliminate waiting in line for license plates. We do it for you • **PAY LESS THAN IF YOU FINANCED IT** We will buy your present car or truck
Call Jim Withrow for all the leasing answers— he'll work with you from start to finish
BOBB CHEVROLET LEASING
567 Livingston Avenue • 228-4567

75% TAX WRITE-OFF INVESTMENT
Above average returns
Excellent documented track record
Innovative personally tailored package to fit your specific needs
Day or Night appointment at your convenience
R.LYLE BARTON & ASSOCIATES
Financial Management Consultants
614/436-5707 614/846-9222
6601 Huntley Rd. Columbus, OH 43229
PETRO OIL CO.
614/439-5563
Rt. 6 Cambridge, OH 43725
SYNDICATED INVESTMENT CO.
614/486-2907
1500 W. Lane Columbus, OH 43221

THREE-IN-ONE THERAPY AGAINST TOPICAL INFECTION



Neosporin® Ointment

(Polymyxin B-Bacitracin-Neomycin)

This potent broad-spectrum antibacterial provides overlapping action to help combat infection caused by common susceptible pathogens (including staph and strep). The petrolatum base is gently occlusive, protective and enhances spreading.

Neomycin

Staphylococcus
Haemophilus
Klebsiella
Aerobacter
Escherichia
Proteus
Corynebacterium
Streptococcus
Pneumococcus

Bacitracin

Staphylococcus
Corynebacterium
Streptococcus
Pneumococcus

Polymyxin B

Pseudomonas
Haemophilus
Klebsiella
Aerobacter
Escherichia

In vitro overlapping antibacterial action of Neosporin® Ointment (polymyxin B-bacitracin-neomycin).

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Neosporin® Ointment

(Polymyxin B-Bacitracin-Neomycin)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

Practice Productivity® Inc. Introduces

practice life

YOUR MEDICAL OFFICE MANAGEMENT REPORT

WHY practice life IS TIMELY FOR YOUR MEDICAL OFFICE.

1. We are aware and proud that the physicians of the United States offer the best medical care in the world. But never before in American history have so many negative forces been at odds with the private practice of providing quality patient care. That's why sound business principles and up-to-date procedures – that **practice life** brings you monthly and in a special annual report – are even more important today.
2. A wide range of ideas are covered. From proven scheduling techniques to how to minimize personnel conflicts. From what's new in computers to new ways to educate your patients. The breadth and scope of **practice life**'s coverage will increase your ability to make necessary decisions more quickly while being more informed.

WHY practice life IS USEFUL.

1. Presented in an easy-to-read, easy-to-refer-to format, **practice life** informs you of significant matters such as new hiring laws and contractual agreements.
2. Its high-quality data, written in precise and lively language, is effective for the medical office that cares.
3. Your time is valuable. And we won't waste a second's worth. That's why **practice life** is written as a practical guide that helps you day after day.
4. **practice life** has a distinct advantage over other sources of practice management information – a competent, full-time staff of Practice Productivity® consultants whose regular contributions come from their daily work of consulting with those of you in private practice.

WHY YOU SHOULD SUBSCRIBE TO practice life.

1. **practice life** is not for everyone. It is for those who deal with change and strive to maintain quality patient care at a reasonable cost. If that is you, order today while it is on your mind.
2. We guarantee **practice life** offers a better way to produce better results – for you. Should you decide to cancel for any reason at any time, your money will be promptly refunded on all unmailed issues.
3. The annual subscription rate of $65.00 – which equals less than 18¢ a day – entitles you to 12 issues of **practice life.** Plus an annual special practice management report.

   Put another way, **practice life** is your "on-site problem-solving consultant" for slightly more than the daily postage of one mailed statement.

   So send your order in immediately. Before you miss a single solution. (And your subscription is tax deductible.)

SEND ME ONE FULL YEAR OF practice life

YES, I understand that the annual subscription rate of $65 (2 years at $115) entitles me to 12 issues plus 1 annual special report. Should I want to cancel for any reason at any time, my money will be promptly refunded on all unmailed issues.

Name _____

Name of Practice _____

Address _____

City _____ State _____ Zip _____

☐ CHECK ENCLOSED ☐ VISA ☐ MASTERCHARGE ☐ 1 YEAR: $65

(Payable to Practice Productivity®)

Signature _____

- Amount _____ • Card No. _____ Exp. Date _____ ☐ 2 YEARS: $115.
- For immediate service call 800-241-6229.

Send To: **Practice Productivity® Inc.**
Publications
2000 Clearview Avenue
Atlanta, Georgia 30340

* **practice life** is a monthly Practice Productivity® publication

A Six-Year Biographic Study of Medical Students at The Ohio State University

Lawrence L. Gabel, Ph.D.
J. Hutchison Williams, M.D.

Biographic data collected from students entering The Ohio State University College of Medicine from 1971 through 1976 are summarized. The discussion encompasses students' responses to questions about their (1) backgrounds, (2) college years, (3) personal skills, and (4) projections of themselves as physicians. Several increasing and decreasing trends are noted. Trends that can be addressed at a local, regional, or national level concerned admissions, educational processes, and eventual medical practice.

EACH YEAR, STUDENTS new to The Ohio State University College of Medicine are asked to complete a biographic inventory. Given recent social concern for "individual rights" and "invasion of privacy," criticism might be made of this practice. However, in medical education, biographic data have been used for medical school admissions,[1] research on medical student characteristics,[2,3] research on specialty choice,[4,5] and research comparing curricular designs.[6] Some biographic variables, such as father's occupation (especially whether or not a physician) and size of community in which the student lived longest have been used more often than have others. Few studies examined more than ten biographic variables.

In January 1977, the 120 medical schools in the United States listed in the *1975-1976 AAMC Curriculum Directory* were surveyed by the authors to determine if they collected biographic data on a continual basis, and if so, how. Sixty-two schools responded: 17 forwarded their biographical instruments; and five indicated a reliance upon the American Medical College Application Service information. Forty indicated no attempt was made to collect biographic data in a formal manner; however, 23 of these indicated an interest in developing an instrument similar to that of The Ohio State University or in seeing a summary of the data collected at Ohio State.

The recently developed "Premedical Students' Questionnaire" completed in conjunction with the *New Medical College Aptitude Test* will allow medical educators to accumulate student biographic data and, hence, to consider expanded research possibilities. In light of this possibility and of the interest shown as a result of the survey, the purposes of this paper are: (1) to share summaries of biographic data collected at Ohio State since 1971; and (2) to suggest potential research and educational uses of such data.

Summary of Data*

The biographic inventory is administered to new students prior to beginning classes at The Ohio State University College of Medicine. Of the 1,360 students entering the College of Medicine from 1971 through 1976, 12 students did not complete the inventory.

Personal Data— Although the ratio of females to males was not constant over the last six years, approximately 17% of the entrants were females. Each year since 1973, the number of entering females has increased by approximately 1%. This increase reflects the applicant pool rather than the admissions process.

When considering the six Health Education Regions of the State of Ohio as determined by the Ohio Board of Regents, it was found that Region I contributed 12% of the entrants over the six years; Region II — 21%; Region III — 22%; Region IV — 11%; Region V — 26%; and Region VI — 9%. (See the Figure.) Regions I, II, III,

Dr. Gabel, Columbus, Research Associate, Division of Research and Evaluation in Medical Education, and Assistant Professor, Department of Family Medicine, The Ohio State University College of Medicine.

Dr. Williams, Columbus, Professor, Department of Obstetrics and Gynecology, and Associate Dean, The Ohio State University College of Medicine; Staff Member, The Ohio State University, Mount Carmel, Riverside Methodist, Grant, and St. Ann's Hospitals, Columbus, and Berger Hospital, Circleville; and OSMA Councilor for the Tenth District.

Submitted April 10, 1978.

*Due to space limitations, supporting tables and graphs are not presented herein. They are available upon request to 3190 Graves Hall, 333 West Tenth Ave., Columbus, Ohio 43210 (Dr. Gabel).

and IV equitably represent the percentages of Ohio population in those regions. Region V is overrepresented, and Region VI is underrepresented. It is interesting to note that even though Region V is overrepresented (mainly because it includes the Columbus metropolitan area), it still contains eight of Ohio's 15 critical medical shortage areas.

Data indicate that family units have been stable over the years. Only 5% of the entrants' parents were divorced; 7% reported their fathers were deceased; and 3% reported their mothers were deceased. Overall, entrants have tended to be the oldest child in the family; however, over the six-year span, there has been an increase in the number of entrants who are middle children. During the last four years of the inventory, 33% of the entrants reported that they had lived most of their lives in suburban areas, and 16% in urban areas of 100,000 or more. However, a trend seems to be developing for entrants to come from smaller population centers.

College Years.— Approximately 70% of the entrants participated in intramural or informal sports, and 17% were involved in formal sports during their college years. Since 1973, entrants report being more involved in traditional organizations such as student government, religious organizations, service fraternities, and academic organizations. During the undergraduate academic years, two thirds of the entrants were employed. Of those, one-fifth worked six to ten hours per week; one-tenth worked 11 to 15 hours; and one-sixth worked 16 to 20 hours. During the summers, 80% of the entrants worked 31 to 50 hours per week.

Entrants viewed themselves as slightly more capable in the biologic sciences than in areas such as chemistry, mathematics, or the behavioral sciences. In terms of "enjoyment," biologic sciences were by far the most "liked" courses at the college level, with this enjoyment increasing with each new class. Foreign languages and administrative science courses were liked the least. In terms of achievement, medical students traditionally have earned high grades in their college years; this trend has become even more pronounced during the period of the inventories. Increasingly, entrants have grade point averages between 3.5 and 4.0, on a 4.0 grade scale, as opposed to 3.0 and 3.5. (Grade inflation, better-prepared students, and the admissions process have all been suggested as rationale for this trend.)

Personal Skills.— When asked about personal skills, the majority of entrants saw themselves as being above average in skill areas which include written and verbal self-expression and ability to stick to problems until solved, to memorize facts, to organize work, to think logically, to create new ideas, and to establish interpersonal relationships. Forty percent of the entrants desired to improve their reading skill. This was followed by public speaking and meeting people, each area noted by 10% of the entrants.

When asked about their relative abilities to compete in medical school, 14% of the students believed they were much better than average, and 51% believed they were better than average. Less than 1% saw themselves as being below average in their ability to compete. Considering the fact that well over half of the entrants saw themselves as having above average abilities, some may have had inflated images of themselves as medical students. Potentially, this could have led to adjustment problems as they commenced their medical school studies. A readministration of the biographic instrument after a few months in medical school might produce different results in the self-assessments of the students.



The Six Health Regions for the State of Ohio as determined by the Ohio Board of Regents.

Becoming a Physician.— It was found that 80% of the entrants first thought of becoming physicians before the age of 18 years, whereas only 36% reported making a final decision to pursue the profession by that age. Over the six years in this study, one half of the entrants have expressed no doubts about choosing medicine as a career. Of the remainder, less than 10% have expressed serious doubts about their decision. The decision to enter the medical profession was influenced in a major way by 23% of the entrants' fathers and by 18% of the entrants' mothers. Physicians known by the entrants had the most influence on the decision to enter the medical profession, influencing 34% of the entrants. Undergraduate teachers and physicians of whom the entrants were aware had major influences on approximately 20% of the entrants.

When asked what they liked best about being a physician, 57% of the entering students chose the ability

to help others, and 20% chose being able to work directly with people. This "people orientation" was also reflected in the fact that approximately 85% of the students wanted to spend 60% or more of their professional time in patient care. Eight percent chose scientific research, and "being one's own boss" was chosen by 7% of the students.

The data analyzed through 1974 suggested that entrants were becoming more desirous of practicing medicine in small towns (less than 9,000 population) or small cities (50,000 to 100,000 population) instead of large towns (10,000 to 50,000 population) or large cities (100,000 or more population). A change in variable values prohibited direct comparisons over the six years. However, there appeared to be a leveling off of this trend in 1975 and 1976. Most entrants felt they would specialize in family/general practice (40%), internal medicine (14%), pediatrics (14%), or surgery (14%). The number choosing family/general practice increased considerably over the six entering years.

Implications

From analysis of the biographic data collected at The Ohio State University College of Medicine since 1971, greater numbers of female students, higher college grade-point averages, and residence in smaller population centers appear to be trends for entering medical students. In addition, entrants seem to be increasingly more interested in biologic sciences and less interested in social sciences. However, eventual medical practice is people oriented.

When beginning their medical school curriculum, new students appear to have strong self-concepts. It might be hypothesized that during the matriculation process, these self-concepts are modified since "average" in medical school differs from "average" in college. What can or should be done with the program to facilitate these changes?

Since most entrants have considered becoming a physician by the age of 18 years and since physicians (not necessarily physicians in the family) are a major influence on the decision to enter the medical profession, it is not surprising that the great majority of entrants choose either general/family practice, internal medicine, pediatrics, or surgery. These are commonly known specialties to most persons. It might be hypothesized that those who choose one of the less-common specialties have some particular reason for doing so— for example, prior illness necessitated contact with the specialty or perhaps it is the specialty of a physician in the family. If there was a desire for persons to choose the less-common specialties early in their education, a concerted effort to introduce students to the specialties soon after entry into medical school might result in rewarding benefit.

Analysis of the data suggests a possible trend for entrants to establish medical practices in small towns or small cities as opposed to large towns or large cities. Is this related to the trend indicating that entrants have lived greater portions of their lives in smaller population centers?

Conclusion

The trends that have been noted give rise to a number of questions. Are these trends merely artifacts of admission policies, or do they reflect changes in the applicant pool? Are similar trends to be found at other institutions? Are they indicative of national trends, or are they regional in nature?

For example, does students' increasing interest in biologic sciences rather than social sciences mean entrants are becoming more technically oriented? What relationships exist between this trend and the noted people orientation in eventual medical practice? What are the medical curriculum implications in light of current social developments such as abortions, euthanasia, malpractice suits, and rising health care costs, as well as social skills such as interpersonal relationships?

Well-planned collection and analysis of data (whether biographic, attitudinal, achievement, or some combination) is necessary work for sound decision-making regarding medical education. Considering the fact that medical students are studying in a dynamic system, it seems reasonable that specialty-choice research, student-characteristic research, and curriculum-evaluation research should be longitudinal in nature. Cliffs' point is quite apropos ". . . it is well to remember that one educates students and that a knowledge of their individual and group characteristics will almost certainly result in better decisions on how to improve their education."[7]

References

1. Milstein RM, Burrow GN, Wilkinson L: Prediction of screening decisions in a medical school admission process. *J Med Educ* **51**:626-633, 1976.

2. Schumacher CF: The 1960 medical school graduate: his biographical history, *J Med Educ* **36**:398-406, 1961.

3. Juan IR, Haley HB: High and low levels of dogmatism in relation to personality, intellectual, and environmental characteristics of medical students. *Psychol Rep* **26**:535-544, 1970.

4. Fishman DB, Zimet CN: Specialty choice and beliefs about specialties among freshmen medical students. *J Med Educ* **47**:524-533, 1972.

5. Weinstein P, Gipple C: Some determinants of career choice in the second year of medical school. *J Med Educ* **50**: 194-198, 1975.

6. Beran RL, et al: *Individualizing the Study of Medicine: The Ohio State University College of Medicine Independent Study Program.* New York, Westinghouse Learning Corp, 1976.

7. Cliff MM, Cliff TM: Attitudes of medical students toward medical school and their future careers. *J Med Educ* **47**: 545-538, 1972.

☆☆☆

The Great Laxative Escape



COLACE®

dioctyl sodium sulfosuccinate

Colace means escape—from laxative stimulation, from laxative harshness, from laxative habit. Colace gently helps soften stools for easy, painless, unstrained elimination. It's the great laxative escape, from infancy to old age. Available in 100 and 50 mg. capsules. Syrup or liquid.

Mead Johnson
PHARMACEUTICAL DIVISION

©1978 Mead Johnson & Company • Evansville, Indiana 47721 U.S.A. 3-78-1



Does it influence your choice of a peripheral/cerebral vasodilator*?

- Vasodilan—compatible with coexisting diseases
- Vasodilan—compatible with concomitant therapy
- Vasodilan—compatible with your total regimen for vascular insufficiency

*Indications: Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily.

Intramuscular 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

U.S. Pat. No. 3,056,836

VASODILAN®

(ISOXSUPRINE HCl)

20-mg tablets

Mead Johnson PHARMACEUTICAL DIVISION

© 1978 MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA 47721 U.S.A. MJL7-4268

Planning and Documenting Continuing Education in the Community Hospital

David S. Stein, Ph.D.
John P. Shultz, M.D.

Community hospitals accredited to sponsor Category 1 continuing medical education programs should develop a system which documents physician attendance and program design. This system should perform four functions: awareness, diagnosis, documentation, and feedback. In addition, the program faculty needs guidelines to design a presentation which satisfies a need and which will effect a change in physician knowledge.

COMMUNITY HOSPITALS accredited to sponsor Category 1 continuing medical education courses have the responsibilty to insure that these meet the definition of planned programs as stated by the Ohio State Medical Association. In addition to quality, the hospital has the responsibilty to document the participation of medical staff members in the programs. This documentation system should identify programs offered, physicians in attendance, and the outcome of each education session.

A planned, continuing medical education program should (1) base subject matter on an identified need, (2) have specific learning objectives, (3) use a variety of education methods to facilitate learning, and (4) provide for evaluation of program and learner accomplishments. A planning system highlighting each of the program elements can provide useful information concerning program design and improvement.

Dr. Stein, Columbus, Director of Education, The Ohio State University Hospitals, and Assistant Professor of Medical Communications, The Ohio State University; previously Director of Education, The Children's Hospital.
Dr. Shultz, Columbus, pediatrician, member Active Staff, Associate Medical Director, and Chairman, Continuing Medical Education Committee, The Children's Hospital.
Submitted June 16, 1978.

One Planning System

At Children's Hospital, Columbus, the continuing medical education committee has developed a systematic means to insure the quality of programs and to record physician participation in each program. This planning system has four primary education functions: awareness, diagnosis, documentation, and feedback.

Awareness.— The planning and documentation system should provide the physician with enough information to permit wise use of learning time. A program might have an interesting title, but have little relevance to a physician's practice; and his/her time could be spent more wisely in some other education endeavor.

A planning and documentation system should provide an overview of the program, emphasizing major points and objectives to be addressed during the session. At Children's Hospital, a description of the program is posted on the continuing medical education bulletin board, and questions concerning the program are directed to the education department.

Diagnosis.— The planning and documentation system also functions as a link between the program faculty and the education advisors. At a primary level, a planning system should help the faculty member systematically consider the goals and objectives of an instructional program. A planning method can provide the faculty member with time for reflecting on the needs of the specific students enrolled in a program. Awareness of the goals and objectives allow faculty members to choose appropriate course content.

At a second level, the planning document can help the education advisor spot deficiencies in the education

design. For example, the document will identify the time allocated for discussion, whether the scope of the program is appropriate for the time allotted, and whether the information is appropriate for the intended audience. In addition, the planning document can assist faculty and education advisors in making recommendations on the potential of the education program to bring about changes in physician knowledge and practice patterns.

At Children's Hospital, all program plans are reviewed by the continuing medical education committee. The instructional process is reviewed by the Hospital's education consultant, and the medical content is reviewed by a physician member of the education committee.

Recording Participation.— The planning document used at Children's Hospital serves as a permanent record of continuing medical education activities conducted at the Hospital. The document provides site evaluators a miniview of the scope and content of the Hospital's continuing education program.

The physician's attendance is recorded on the planning form and entered on an individual transcript. The

The Children's Hospital
Columbus, Ohio

Continuing Medical Education Program Evaluation

Directions: Please complete this form and return it to the Education Department. Receipt of this form will be necessary before a credit slip can be issued.

NAME OF PROGRAM: _____

Please check the appropriate box: DATE: _____

	POOR	FAIR	GOOD	EXCELLENT
1. Quality of material				
2. Organization of material				
3. Improved your understanding?				
4. Usefulness of material to you				
5. Speaker's delivery				
6. Quality of audio-visuals				
7. Opportunity for discussion				
8. How will you be able to apply the information presented in your practice?				

FIG. 1. Program evaluation form.

The Children's Hospital
Columbus, Ohio

Continuing Medical Education Program Plan

Topic: Renal Failure in Newborns and Young Infants **Sponsoring Dept.:** Pediatrics

Date: December 29, 1976 **Credit:** 1 Hour **Approved:** Yes

WHY IS THIS TOPIC BEING PRESENTED? The frequency of infants admitted with renal failure has increased. Renal failure is difficult to diagnose and is frequently missed.

WHAT CHANGES IN KNOWLEDGE, SKILLS OR ATTITUDE SHOULD RESULT? Physicians will be able to recognize the symptoms of renal failure in the infant. Presented with the symptoms of renal failure, the physician will be able to make the correct diagnosis, and prescribe appropriate treatment.

PLEASE LIST ANY AUDIO-VISUAL EQUIPMENT NEEDED: _____

Time	Activity (ie, lecture, case study)	Outline of Content	Instructor(s)	Evaluation
8:00	Case study	A case of two infants with renal failure is presented. The case includes history, diagnosis, and management. Discussion concerning the case follows the presentation.	House staff	Program evaluation will be accomplished through a learner reaction instrument.
8:15	Renal aspects	A mini-lecture/discussion on the symptomatology of renal failure in the infant. The etiology of renal failure will be presented with attention to obstructive uropathy.	Dr. S	
8:30	Management and diagnosis	A mini-lecture on the clinical symptoms indicating renal failure in the newborn will be presented. Laboratory tests will be discussed. Management of the disorder also will be discussed.	Dr. B	
8:45	Surgical management	Appropriate surgical interventions will be discussed.	Dr. M	
9:00	Adjournment			

Program Summary:

FIG. 2. Description of a continuing medical education program.

transcript lists program titles, date, and credit hours. Verification of attendance is available by course content or program date. The Hospital will furnish the physician a record of all Category 1 activities in which the individual participated. Credits from other institutions will be entered on the physician transcript if adequate documentation is provided to the medical education office. Category 2 credits are not entered on the individual transcript.

Feedback.— The planning document contains a section titled "program summary." This section provides information to the education consultant on the effectiveness of the learning design, the significant outcomes of the conference, and the need for further courses on the same or different topics. Gathered from the vantage point of the program sponsor, this information is correlated with program evaluation data received from individual participants. (See Fig. 1.) An evaluation summary report is sent to the program faculty.

Continuing Education Program Plan

The continuing medical education program plan is a two-part document which describes the program's significant learning aspects. (See Fig. 2.) All departments sponsoring a Category 1 program must complete the plan before credit will be assigned. The program chairman must communicate the objectives and need for the program to the faculty, who will advise the chairman on the content to be included in the program. In this manner, correlation is assured between the need for the program and the information provided.

Each chairman receives a copy of "Guidelines for Planning and Documenting Continuing Medical Education Activities," published by Children's Hospital. The guidelines outline the steps to be completed when planning an effective medical education program. The guidelines stress the following:

Why is this topic presented?— Continuing medical education programs should be derived from learning needs that are identified through medical audits, self-assessment techniques, peer review, new developments in medical knowledge, or review of basic core knowledge.

What changes in knowledge, skill, or attitudes are desired?— A successful continuing medical education program should result in improvements in knowledge, skill, or attitudes of the participants. (ie, diagnose and prescribe . . ., recognize signs and symptoms of . . ., or manage problems associated with . . .).

What is the content?— A variety of education techniques and learning methods can be used when conducting a continuing medical education program. Those planning the program should determine what subjects are to be covered and by what education methods. At this juncture in planning, any supporting material to be used in the course should be attached to the planning document (ie, case histories, course outlines, handouts, and bibliographies).

How will the course be evaluated?— The achievement of learning objectives should be evaluated by measuring program quality, changes in knowledge, and changes in the quality of patient care. All Category 1 programs at Children's Hospital are evaluated with a learner-reaction device. This instrument measures a participant's reaction to the information presented and to the instruction process.

How is attendance documented?— During the program, physician attendance should be recorded on the program planning guide. Following compilation of an evaluation summary of the program, participation should be documented on a transcript and a copy of the program's plan should be placed on file in the education department.

Summary

All community hospitals which offer Category 1 continuing medical education programs must have a system for planning and documentation of these programs. In effect for the past 18 months, the system at Children's Hospital provides an accurate and complete record of continuing medical education programs. In addition, physicians may obtain a complete transcript of their participation in the education process. ☆☆☆

Our 70th Year

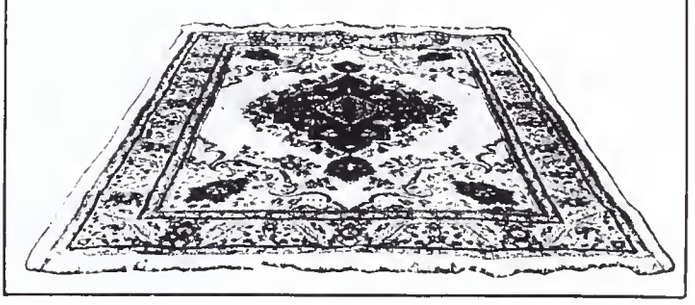
K. A. Menendian
has been known for
the finest quality and best values in
ORIENTAL RUGS.

We carry a complete selection of rugs from mats to mansion sizes. Over 1500 rugs in stock from Iran, India, China, Pakistan, Turkey, etc.

See over 4,000 samples in our newly remodeled carpet showroom from Karastan and other fine mills.

We specialize in Oriental rug cleaning and repairing.

K.A.Menendian
1090 West Fifth Avenue
294-3345



Accept no substitute for your professional judgment

As a physician, you have the right to prescribe the drug which you believe will most benefit your patients. Now, substitution laws make it more difficult to exercise that right. In many states, unless you specifically direct pharmacists to dispense your brand-name prescription as written, they may be required by law to substitute another drug for your brand-name prescription.

This means that the ultimate drug selection is no longer yours; its source is left to the pharmacist's discretion. You will have forfeited your right to prescribe as you see fit. Preserve your rights. Specify that you will accept no substitution.

When you accept no substitutes...

- You ensure that your patient receives exactly that product you have specified on your prescription
- You choose the quality of the product dispensed to your patient
- You can exercise the right to select a product based upon its proven therapeutic performance and to select a manufacturer that stands behind its brand name or generic product
- You can support the kinds of research programs that are vital to new drug discovery and development
- You can help sustain important physician, pharmacist and patient education services supported by innovative, research-oriented firms

For complete information on the drug substitution law effective in your state, please consult your local Pfizer Representative.

© 1978, Pfizer Inc

Pfizer PHARMACEUTICALS

The Ohio State Medical Association News

AMA Leadership Conference

The American Medical Association will hold its 1979 National Leadership Conference February 15 through 18 at the Downtown Marriott Hotel, Chicago. "Homeostasis" in the federation and maintaining credibility in the world outside the realm of medicine is the theme of the meeting which will stress health care costs, membership, medical society public relations, and national health insurance. Several preconference optional seminars will be held on February 15, with the official opening of the Leadership Conference on Friday, February 16. The registration fee is $100 for AMA members. For further information, contact AMA Headquarters, 535 N. Dearborn St., Chicago, Illinois 60610, telephone: 312/751-6000.

Florida Physicians to Advertise on Radio and Television

Recently, the Florida State Board of Medical Examiners took action to allow physicians to advertise through the electronic media. This action expanded an earlier ruling allowing physicians to advertise in newspapers.

O. William Davenport, President of the Florida Medical Association, said that he does not foresee this action affecting the Association's current ethical standards for professional advertising. Citing the American Medical Association's principles of medical ethics, which are adhered to by the FMA, Dr. Davenport noted that these principles do not proscribe advertising, but proscribe solicitation of patients. He said the freedom to choose a physician and free competition among physicians are prerequisites of optimum medical care.

Indicating that the FMA will take great interest in the criteria that will be established by the State Board of Medical Examiners in allowing physicians to use the electronic media, Dr. Davenport stated: "In setting forth ethical guidelines for physicians to follow in their practice, it is our intention to curtail abusive practice that will impinge on these freedoms and exploit patients and the public."

Louisiana Medical Malpractice Act Challenged in Courts

The Louisiana Medical Malpractice Act has been challenged in the courts and still is intact. The Supreme Court of Louisiana has overturned the ruling of the lower courts, which held four of the Act's sections to be invalid. The Supreme Court gave the legislation full judicial sanction.

A claim for damages against three physicians initiated the test of the constitutionality of the Act. The plaintiffs disregarded the procedures required by the state's Medical Malpractice Act. In responding to an objection by one of the defendant physicians, the plaintiff challenged the constitutionality of the legislation and the issue was joined.

Under the provisions of the Louisiana Medical Malpractice Act, any provider of health care can be covered by the law if he/she maintains a malpractice insurance policy of $100,000 or has assets personally to meet a claim of that state. Also, the provider must pay a surcharge into a special fund. This surcharge cannot exceed 20% of the premium costs of the $100,000 malpractice insurance policy.

By qualifying for coverage under the law, a provider can never be held personally liable for more than $100,000. The surcharge fund is designed to pay awards in excess of $100,000; however, no award can exceed $500,000 in damages.

In addition, the plaintiff is not to stipulate any sum of money— only to ask for "such damages as are responsible." The case initially must be submitted to a panel of physicians chaired by a nonvoting attorney. Although this panel can make no damage awards, it does offer an opinion on the medical merits of the case which is admissible in court proceedings. This action was designed to encourage nonmeritorious suits to be withdrawn and meritorious ones to be settled out of court.

Arthritis Care Program Open to Ohio Physicians

The Arthritis Care and Education (ACE) Program is designed to provide physicians with the latest information concerning arthritis treatment. The first program of its kind to be state funded, ACE is under the direction of the Ohio Department of Health and is administered by the Arthritis Foundation Chapters in Ohio.

Practicing physicians may participate in four-week fellowships that are available in each of the four Arthritis Foundation districts in Ohio. ACE participants will study all aspects of connective tissue disease during the program which has been tailored to the time considerations and background of each physician. The program format will consist of at least two one-week periods of continuous, structured training with the remainder of the program arranged on an individual basis. Each physician will receive a stipend of $2,000, and the program has been approved for 50 hours of Category 1 continuing education credit.

(continued on next page)

News *(continued)*

Practicing physicians interested in the ACE program can obtain further information and applications from the Arthritis Foundation Chapter in their areas:
Toledo.— Allan Kirsner, M.D., Project Director, The Arthritis Foundation, 3817 Monroe St., Toledo 43606.
Cincinnati.— Evelyn Hess, M.D., Project Director, The Arthritis Foundation, 2400 Reading Rd., Cincinnati 45202.
Cleveland.— Ray Scheetz, M.D., Project Director, The Arthritis Foundation, 2239 East 55th Street, Cleveland 44103.
Columbus.— Jack C. Bass, M.D., Project Director, The Arthritis Foundation, 2501 N. Star Rd., Columbus 43221.

Individual Practice Associations Topic of Regional Seminars

The American Association of Foundations for Medical Care will conduct a series of seminars on individual practice associations (IPAs). Six regional sessions have been planned in response to the growing demand by physicians and the general public for information on this subject. The first session was held in Chicago. The remaining schedule is as follows:

San Francisco—January 25-27, 1979; **Denver**—February 8-10, 1979; **Philadelphia**— March 29-31, 1979; **Atlanta**— April 19-21, 1979; and **Boston**— May 24-26, 1979.

Registration information is available through the American Association of Foundations for Medical Care, P.O. Box 230, Stockton, California 95201, telephone: 209/948-6656.

Anesthesiologists Sign FTC Order

The American Society of Anesthesiologists has signed a consent agreement presented to the Society by the Federal Trade Commission. Subject to a period for public comment, anesthesiologists no longer have to follow the Society's guidelines which advise fee-for-service compensation; and they may become salaried employees of hospitals. The Federal Trade Commission believes that the effect of the consent agreement will be more competition, potentially lower charges among anesthesiologists, and resulting reduction in hospital bills.

Lorain County Awards Scholarships

The Lorain County Medical Foundation has awarded scholarships totaling $4,100 to local residents who are engaged in study in a medical field. The 14 recipients were

TREAT THE SYMPTOMS IN THE GERIATRIC PATIENT

APATHY • IRRITABILITY
FORGETFULNESS • CONFUSION



Cerebro-Nicin® CAPSULES

A GENTLE CEREBRAL STIMULANT & VASODILATOR FOR GERIATRIC PATIENTS

Each CEREBRO-NICIN capsule contains:
Pentylenetetrazole .....100 mg. • Nicotinic Acid ...100 mg.
Ascorbic Acid .....100 mg. • Thiamine HCl .....25 mg.
l-Glutamic Acid .....50 mg. • Niacinamide .....5 mg.
Riboflavin .....2 mg. • Pyridoxine HCl .....3 mg.
AVAILABLE: Bottles 100, 500, 1000
SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and abdominal cramps. The reaction is usually transient.
INDICATIONS: As a cerebral stimulant and vasodilator.
RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.
WARNING: Overdosage may cause muscle tremor and convulsions.
CONTRAINDICATIONS: Epilepsy or low convulsive threshold.
CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

Write for literature and samples . . .
BROWN THE BROWN PHARMACEUTICAL CO.
2500 W. 6th St., Los Angeles, Calif. 90057

chosen from among 69 applicants and included the following medical students: Thomas Billings, Elyria, University of Cincinnati College of Medicine; Nancy M. Gilles, Elyria, University of St. Louis College of Medicine; Holly Gae Henderson, Amherst, Wright State University School of Medicine; and Richard J. Kovacs, Elyria, University of Cincinnati College of Medicine. John B. McCoy, M.D., chaired the Screening Committee that selected the recipients.

This year's scholarships bring the total amount awarded by the Medical Foundation to $43,875 since its inception in 1963. The Auxiliary of the Lorain County Medical Society has been a prime benefactor of the Foundation's scholarship program, having contributed $33,640 since 1968.

Illinois Overturns Limit on Suits

The Illinois State Appellate Court has overturned a law which sets a four-year limit on all suits against physicians or hospitals involving patient care. The court indicated that this was "special legislation" contrary to the Illinois Constitution. In addition, it noted that immunity was granted to physicians and hospitals but denied to other health-care personnel and institutions.

Medical Board Activities

The following is a list of activities and actions undertaken from July 1, 1978 to September 30, 1978 by the Ohio State Medical Board.

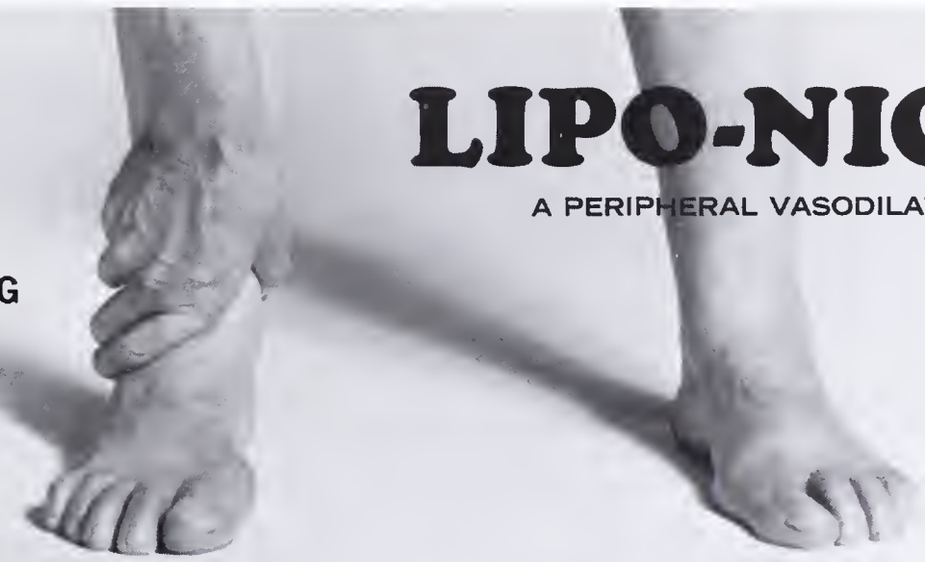
LICENSURE ACTIVITY

American and Canadian Graduates		
Licensed by Endorsement	M.D.	315
	D.O.	76
Licensed by Examination	M.D.	85
	D.O.	5
Foreign Medical School Graduates		
Licensed by Endorsement		148
Licensed by Examination		36
Sept. 1972 FLEX Board Policy Licenses		2
Endorsements to Other States	M.D.	121
	D.O.	10

ENFORCEMENT ACTIVITY

Formal Citations Issued	3
Board Office Visits with Individuals in Alleged Violation of the Medical Practice Act	16
Voluntary Surrenders of Medical Certificates	2
Arrests for Alleged Illegal Practice of Medicine	0
Formal Hearings on Alleged Violations of the Medical Practice Act.	5

COLD FEET
LEG CRAMPS
TINNITUS
DISCOMFORT ON STANDING



LIPO-NICIN
A PERIPHERAL VASODILATOR

IMMEDIATE or GRADUAL
nicotinic acid therapy

IMMEDIATE RELEASE

LIPO-NICIN/100 mg.
Each blue tablet contains:
Nicotinic Acid .....100 mg.
Niacinamide ..... 75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .. 25 mg.
Riboflavin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6).. 10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500, 1000.

LIPO-NICIN/250 mg.
Each yellow tablet contains:
Nicotinic Acid .....250 mg.
Niacinamide ..... 75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .. 25 mg.
Riboflavin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6).. 10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500, 1000.

GRADUAL RELEASE

LIPO-NICIN/300 mg.
Each time-release capsule contains:
Nicotinic Acid .....300 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (H-1) .. 25 mg.
Riboflavin (B-2) ..... 2 mg.
Pyridoxine HCL (B-6).. 10 mg.
In a special base of prolonged therapeutic effect.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient. Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur. Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

BROWN THE BROWN PHARMACEUTICAL CO., INC. 2500 West Sixth Street, Los Angeles, California 90057
Write for Literature and Samples
REFER TO PDR

The Ohio State Medical Association New Members

CLARK (Springfield)

John R. Buscher
Kwang Hyun Kim
Roland G. Lowden
Siva Vemana

CLINTON (Wilmington)

Tumkur Shivashankare

CUYAHOGA (Cleveland)

Bruce E. Babula
Julie A. Brous
Keith Byers
Evangeline C. Cunningham
Armando B. Damian, Jr.
Carmencita Damian
Brigida M. DeLeon
Charlotte V. Delhaes
David L. Green
Alan R. Gurd
Enrique Huerta
James J. Izanec
Randall S. Krakauer
Robert D. Wagar
Stephen M. Weiss
William S. Wilkie

DEFIANCE (Defiance)

Francis G. Belardi

FRANKLIN (Columbus unless noted)

Donald L. Brown, Worthington
Louis P. Caravella
Charles A. Derrow
Frank E. Isabelle
Chang Zoon Kim
Stanley G. Sateren
Richard G. Thomas
Stephanie W. Thomas

GALLIA (Gallipolis)

Harry Amsbary

HAMILTON (Cincinnati)

John R. Babcock
Richard P. Corbin
James P. Duffy
Igor Dumbadze
Saeed Esmaili
Dorothy L. Ferris
Robert R. Flanagan
David Garver
Howard Z. Gelbart
Nancy J. Goldenberg
Ronald Grusd
Edward C. Hall
Kyu-Hwan Kim
Richard G. Klopp
Michael S. Kranbuhl
George Kranias
Wilfried Leder
Richard R. Lichte
Michael C. Maeder
Joseph McEvoy
Joseph J. Mravec
Howard S. Paul
Harold Pearson
Alter G. Peerless
Emil R. Popescu
Anthony V. Proto
Marie B. Rhyne
John J. Robinson, Jr.
David E. Schlueter
Mahmud Shah
Som Nath Tandon
Albert Weisbrot
Michael C. Welch
Frank Welsh
William M. Whitley

HARRISON (Jewett)

Prasad R. Siripurapu

LAWRENCE (Ironton)

Basayeswararaq Yalamanchili

LUCAS (Toledo)

Michael R. Hay
Allan S. Kaufman
Pierre A. Vauthy
Steven M. Wagner
John A. Winder

MEDINA

William R. Kendall, Wadsworth
Konstantin Kuschnir, Brunswick

MONTGOMERY (Dayton)

William M. Matre
Christopher J. Meier
Maheschandra G. Sastry

MUSKINGUM (Zanesville)

William F. Pomputius, Jr.

PERRY (New Lexington)

William A. Brown, Jr.

PIKE (Waverly)

Darrell K. Wells

SCIOTO (Wheelersburg)

Jagdish D. Kulkarni

STARK (Canton unless noted)

Gregory Gray
James Taddeo, Alliance
Stanley Weitzner

SUMMIT (Akron)

George W. Carroll
Joseph A. Crawford
Peter D. Rogers

WASHINGTON (Marietta)

Lewis W. Coppel, Jr.

Harding Hospital

ACCREDITED BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

MEMBER BLUE CROSS OF CENTRAL OHIO

ADMISSION AND PRACTICES CONDUCTED WITHOUT REGARD TO RACE, CREED, OR NATIONAL ORIGIN

Offering a Full Range of Psychiatric Services

- ★ Inpatient Services for 120
- ★ Individual and Group Psychotherapy
- ★ Professional Adjunctive Therapy
- ★ Family Therapy
- ★ Special Care for the Disturbed Patient
- ★ Day Treatment for Adults and Adolescents
- ★ Halfway House
- ★ Family Care
- ★ Outpatient Treatment
- ★ Consultation and Evaluation
- ★ Special Program for Adolescents, Including School

For further information, call (614) 885-5381

George T. Harding, Jr., M.D.
Medical Director

Donald L Hanson
Administrator

445 East Granville Road
Worthington, Ohio 43085

IMMKE CIRCLE LEASING INC

Endorsed Leasing Company
Of The Ohio State Medical Association

Order now for early delivery on all 1979 models

We lease all foreign and domestic makes and models including Mercedes, Jaguar, Porsche, etc.

Many people think of leasing as just automobiles.
We do that too, but, in addition, we want to lease you any professional equipment.

Immke Circle Leasing, Inc.
32 South Fifth Street
Columbus, Ohio 43215

Telephone 614-228-1701 or Toll Free 1-800-282-0256

THE OHIO STATE Medical Association

Colleagues in the News

ELIZABETH R. APLIN, M.D., Columbus, has received the Job Lewis Smith Award of the Section on Community Pediatrics of the American Academy of Pediatrics. A Fellow of the Academy, Dr. Aplin is Clinical Professor of Pediatrics Emeritus at The Ohio State University, former director of the Ohio Service for Crippled Children, and chairman of the Ohio Chapter of the American Academy of Pediatrics.

ALAN ASHARE, M.D., Dayton, received a Certificate of Merit Award for his exhibit, entitled "How Hard is a ROC," at the June meeting of the Society of Nuclear Medicine. Dr. Ashare is Associate Professor and Chairman of the Department of Radiological Sciences at Wright State University School of Medicine.

BARRETT H. BOLTON, M.D., Dayton, received a plaque from the Internal Medicine House Staff of Miami Valley Hospital in recognition of his outstanding service. Dr. Bolton is Associate Clinical Professor of Medicine at Wright State University School of Medicine.

JOHN D. BULLOCK, M.D., Dayton, has been invited to serve on the Ophthalmological Services Manpower Committee of the American Academy of Ophthalmology. Dr. Bullock is Assistant Clinical Professor of Ophthalmology at Wright State University School of Medicine.

CLINT CHAMBERS, M.D., Dayton, has been certified by the American Board of Colon and Rectal Surgery. Dr. Chambers is Assistant Clinical Professor of Surgery at Wright State University School of Medicine.

Three members of the Department of Surgery at Wright State University School of Medicine have been named Fellows of the American College of Surgeons: **PRIVAKANT DESAI, M.D.,** Xenia, Associate Clinical Professor; **AZHER QUADER, M.D.,** Troy, Assistant Clinical Professor; and **LT. COL. PETER SANFELIPPO, M.D., Dayton,** Associate Clinical Professor.

JOSE ESPINIELLA, M.D., Centerville, has been honored for outstanding service to veterans by the Disabled American Veterans. Dr. Espiniella is Assistant Clinical Professor of Surgery at Wright State University School of Medicine.

RICHARD G. FARMER, M.D., Cleveland, has been elected President of the American College of Gastroenterology. Dr. Farmer is head of the Department of Gastroenterology at the Cleveland Clinic Foundation, chairman of the Division of Medicine, and a member of the Board of Governors. In addition, he is a member of the National Commission of Digestive Diseases, president of the Association of Program Directors in Internal Medicine, and member of the Council for the Federation of Digestive Diseases Society.

ARTHUR T. EVANS, M.D., Cincinnati, has been elected President of the newly formed Ohio Urological Society. **SIGMUND R. SUGARMAN, M.D.,** Cincinnati, is Secretary-Treasurer.

RONALD H. FEGELMAN, M.D., Wyoming, has been appointed Director of the Department of Surgery at The Jewish Hospital, Cincinnati. A member of the Medical Staff since 1965, Dr. Fegelman has served in several capacities including secretary of the Medical Staff and member of the Hospital's Board of Trustees. He was serving as Acting Director of Surgery until this appointment. Dr. Fegelman is a Fellow of the American College of Surgeons, Diplomate of the American Board of Surgery, and Assistant Clinical Professor of Surgery at the University of Cincinnati.

The trustees and provost of the Northeastern Ohio Universities College of Medicine have established the Medical Education Foundation of the College of Medicine. Among those signing the articles of incorporation were trustees **JAMES E. FLEMING, M.D.,** Cleveland, and **ROBERT E. TSCHANTZ, M.D.,** Canton; and **STANLEY W. OLSON, M.D.,** Rootstown, provost of the College of Medicine.

The following Ohioans have joined the American College of Radiologists: **BOKYUNG K. HAN, M.D.,** Cincinnati; **TOMAS H. IRIZARRY-CONCEPCION, M.D.,** Fairborn; **VIRGINIA L. LAMPERT, M.D.,** Richmond Heights; **LEVONA W. OLMSTED, M.D.,** Cleveland; **VIKRAM A. RAVEL, M.D.,** Youngstown; **PANNEE SIRIPONG, M.D.,** Girard; and **BELEN P. VARGAS, M.D.,** Steubenville.

SCOTT R. INKLEY, M.D., Brecksville, has been appointed Chief of Staff of University Hospitals in Cleveland. A leader in the research and treatment of lung diseases, Dr. Inkley will succeed **WALTER H. PRITCHARD, M.D.,** Cleveland, who had served in the position since 1971. Dr. Pritchard also is the Argyl J. Beams Professor of Medicine at Case Western Reserve University School of Medicine.

KAZOU K. KIMURA, M.D., Ph.D., Dayton, has been invited to serve on the Governing Board of Directors of the American Board of Clinical Pharmacology, Inc. Dr. Kimura is Professor of Pharmacology at Wright State University School of Medicine.

JOHN O. LINDOWER, M.D., Ph.D., Dayton, has been asked to serve on the Commission on Accrediting for the Association of Theological Schools in the United States and Canada. Dr. Lindower is Professor and Chairman of the Department of Pharmacology at Wright State University School of Medicine.

LAWRENCE J. McCORMACK, M.D., Lyndhurst, has been installed as President-Elect of the College of American Pathologists. A specialist in pulmonary and renal disease, Dr. McCormack is the senior member of the Department of Pathology of the Cleveland Clinic Foundation, which he joined in 1951.

WILLIAM B. MERRYMAN, M.D., Columbus, has been promoted to Brigadier General in the U.S. Army Reserve. A veteran of 36 years in the military, he is the commander of the 2291st U.S. Army Hospital, located in Whitehall, and has served as the commander of the 307th Medical Group, located in Columbus. Dr. Merryman has been awarded the Army Commendation Medal, World War II Victory Medal, American Theatre Ribbon, and the Reserve Components Achievement Medal with second award. A 1975 graduate of the Command and General Staff College at Fort Leavenworth, Kansas, he is in the private practice of obstetrics and gynecology.

STANLEY MOHLER, M.D., Dayton, has been named Professor of Community Medicine and Director of the Aerospace Medicine Residency Program at Wright State University School of Medicine. Wright State offers the only civilian aerospace medicine residency program in the United States. Dr. Mohler had served as Chief of the Aeromedical Applications Division of the Federal Aviation Administration since 1965. He is a Diplomate of the American Board of Preventive Medicine, Fellow of the Aerospace Medical Association, and Fellow of the Gerontological Society.

JOHN P. SCHLEMMER, M.D., Akron, is the director of the Year IV "Principles of Ambulatory Care" program at Northeastern Ohio Universities College of Medicine (NEOUCOM). The charter class of the College of Medicine has begun its Year IV studies, which include this course that encourages a physician to be concerned with the "person" of the patient as well as the disease. Dr. Schlemmer is Chairman of the NEOUCOM Council of Family Medicine and Director of the West Side Family Practice Center, Akron General Medical Center.

DAVID C. SCWARTZ, M.D., Cincinnati, American College of Cardiology Governor for the State of Ohio, has announced the names of those physicians in his geographic area who have achieved Fellowship in the College. Those Ohioans newly admitted to Fellowship in the 9,000-member organization are:

SIMON OHANESSIAN, M.D., Chardon;

MAHMOUD H. ADAM, M.D., THOMAS J. COMERFORD, M.D., FREDERICK A. HEUPLER, JR., M.D., HARRY M. LEVER, M.D., FREDERICK A. OLDENBURG, M.D., EREST0 E. SALCEDO, M.D., and **SANTOS A. UY, JR., M.D.,** Cleveland;

LEE ROY DAVIS, M.D., Columbus;

DAVID C. JOFFE, M.D., Dayton;

FAROUK A. J. TABRAH, M.D., Kettering;

EDWARD E. H. LAO, M.D., Parma;

EVERETT M. BUSH, M.D., and **SUBHASH C. KHULLAR,** M.D., Toledo; and

VIJAY B. BEHARI, M.B., B.S., Warren.

OTTO S. STEINREICH, M.D., Akron, has been appointed Associate Dean of Clinical Sciences at Northeastern Ohio Universities College of Medicine. Currently Director of Medical Education at St. Thomas Hospital Medical Center, Dr. Steinreich has been involved in the teaching of nurses and residents at St. Thomas for 37 years. In addition, he was instrumental in the planning and development of the Family Practice Center there.

HENRY A. WISE II, M.D., Columbus, has been appointed Director of the Division of Urology at The Ohio State University. Dr. Wise replaces **CHESTER C. WINTER, M.D.,** who will continue with the University but has expressed an interest in devoting more time to research and teaching.

ROBERT S. YOUNG, M.D., Johnstown, has been elected to the Board of Directors of the American Academy of Family Physicians. Dr. Young, who will serve a term of three years, also is Consulting Medical Editor of the OSMA patient publication *Synergy*.

JOSEPH P. YUT, M.D., North Canton, has been appointed to the Ohio State Medical Board. Dr. Yut is a delegate to the OSMA House of Delegates and a past president of the Stark County Medical Society.

"Colleagues in the News" is sponsored by



Blue Shield

Ohio Medical Indemnity, Inc.

6740 North High Street, Worthington, Ohio 43085

(614) 438-3500

(PAID ADVERTISEMENT)

Classified Ads

Rates: $3 per line. Display classified: $5 per line. Minimum 3 lines per insertion. Ads measure 8 lines to the inch. Box number reply: Flat $5 charge in addition to line cost for up to and including three insertions. (Covers cost of mailing replies which are kept confidential.) Forms close the 10th day of the month preceding month of publication. Address all ads Attention: Classified Ad Department, ***The Journal.***

To assure prompt delivery, when replying to an advertisement over a ***Journal*** box number, address letters as follows: Box (insert number), c/o ***The Ohio State Medical Journal***, 600 South High Street, Columbus, Ohio 43215.

OBSTETRICIAN/GYNECOLOGIST WANTED: For 47-physician multispecialty group located in a prosperous central Ohio community. Present department includes three physicians with a large gynecologic practice and presently performing approximately 600 deliveries per year. Attractive salary and unusual fringes, including retirement program; early partnership with no financial investment. Send C.V. or call collect to Bruce Dyer, Executive Director, F. C. Smith Clinic, 1040 Delaware Avenue, Marion, Ohio 43302, phone 614/387-0850.

PHYSICIANS

Seeking full- or part-time physicians to provide general medical services. Daytime hours preferred. Ohio license/eligibility required. Rural residential MR/DD habilitation center with interdisciplinary approach. Salary negotiable. Send resume to Ms. A. Lambert, Office of Planning and Implementation, Apple Creek State Institute, Box 148, Apple Creek, Ohio 44606, phone: 216/698-2411 ext. 363.

An Affirmative Action
Equal Opportunity Employer

DERMATOLOGY PRACTICE: Five-year, well-established practice. Good location in suburb of Cleveland. Potential is great. Present gross income over $100,000. Terms negotiable. Please write: 32915 Aurora Rd., Solon, Ohio 44139 or phone: 216/248-4827.

LOCUM TENENS-EMERGENCY MEDICINE: Available in our 100 hospitals. Monthly scheduling is flexible and according to your preferences. Malpractice is paid, excellent hourly income according to your flexibility and hours worked. Send C.V. to James Ginter, 931 Chatham Road, Columbus, Ohio 43221 or call 614/457-9761.

CARDIOLOGIST: Thirty-year-old, ABIM-eligible physician. Will be eligible for cardiology boards June 1979. CATH training at prestigious university in California. Well trained in noninvasive techniques, pacemakers, and swanganz. Seeks group/partnership or hospital practice. Available July 1979. Will do some internal medicine. Reply Box No. 847 c/o Ohio State Medical Journal.

CLINICAL MEDICAL DIRECTOR

Federally funded Community Mental Health Center is seeking a licensed psychiatrist for the challenging opportunity of establishing and administering its service programs. Salary $40,000 + excellent, paid fringe-benefit package. Salary can be supplemented with limited private practice. Send C.V. or call John Albrinck, Exec. Dir., Mental Health Services Northwest, 8228 Winton Rd., Cincinnati, OH 45231, phone 513/729-5434.

An Equal Opportunity Employer

OPHTHALMOLOGIST WANTED: General private practice. Vacated due to ill health. Contact: R. L. Shilling, M.D., 418 Washington Ave., Elyria, OH 44035, phone: 216/322-6722.

PEDIATRICIAN: To administer the Title V Crippled Children's Services Program in Ohio. Responsibilities include developing, monitoring, and evaluating Crippled Children's Services throughout the state. This position affords a challenging opportunity to develop further a long-standing, well-recognized program as Chief of Ohio's Bureau of Crippled Children's Services. Qualified applicants will be licensed to practice medicine in Ohio or eligible for licensure; be board certified in pediatrics or an appropriate related specialty; have experience in pediatrics and demonstrated administrative skills in organizational management. Salary range $30,638-$41,059 per year plus attractive fringe-benefit package. Please contact Director, Ohio Department of Health, P.O. Box 118, Columbus, Ohio 43216.

FULL-TIME EMERGENCY PHYSICIAN IN OHIO: Near Cleveland, Akron, and Youngstown. Write to: S. Sami Solu, M.D. c/o Emergency Department, Robinson Memorial Hospital, Ravenna, Ohio 44266.

GENERAL PRACTICE PHYSICIAN FOR RURAL AREA: Small rural hospital with available office space. Located in northcentral Ohio, 12,000 population area, between Cleveland and Columbus. Prime agriculture-recreation area, with numerous rivers and state park. Major shopping areas and medical centers located within 20 miles. Write or call collect: DAVID HAHN, Adm., Kettering Hospital, Loudonville, OH 44842, phone 419/994-4121.

FAMILY PRACTICE — RURAL PRACTICE: Northwest/central rural/agrarian community of 1200/1500 needs family practice physician. Practice could expand to cover 3000/3500 population area. No physician now practicing. Community will support. Major regional hospital within driving distance. Contact *ROBERT FLINT*, **MARION HOSPITAL, MARION, OHIO** 43302, phone: 614/387-8810 or 387-5442.

EMERGENCY PHYSICIAN POSITION AVAILABLE: New medical center in Wheeling, West Virginia, adjacent to Interstate 70 just one hour from Pittsburgh. Good salary and executive fringe benefit package including paid educational time off and educational allowance. Congenial staff and outstanding relationship between staff and administration. Area offers cultural and recreational opportunities, including well-known Oglebay Park, without big city problems. Send curriculum vitae to G. M. Kellas, M.D., Medical Director, Wheeling Hospital, Medical Park, Wheeling, WV 26003, phone: 304/242-7870.

GENERAL MEDICAL OFFICES AVAILABLE FOR RENT: In Hartville, reportedly the fastest growing township in Ohio. New construction permitting individual furnishing. Physically attached to Cancer Center with diagnostic x-ray, laboratory, and pharmacy facilities. Contact George N. Swallon Agency, Canton, Ohio, 216/456-3495, or inquire of R. K. Loeffler, M.D., 650 South Prospect, Hartville, Ohio 44632.

GENERAL PRACTICE PHYSICIAN WANTED: Office space available. $100,000 first-year potential. Northcentral Ohio, population area 25,000. Ideal environment, excellent sports, recreational facilities, boating nearby. Midway Cleveland-Toledo, 100 miles north Columbus. Modern 68-bed hospital. Good schools. Brochure on request. Write T. R. Ball, M.D., Box 309, Bellevue, Ohio 44811.

PEDIATRICIAN WANTED: For 47-physician multispecialty group located in a prosperous Central Ohio community. Present Department includes four pediatricians providing 37,000 outpatient visits yearly. Attractive salary and unusual fringes, including retirement program; early partnership with no financial investment. Send C.V. or call collect to Albert N. May, M.D. or Bruce Dyer, Executive Director, F. C. Smith Clinic, 1040 Delaware Avenue, Marion, Ohio 43302, phone 614/387-0850.

GARFIELD HTS., OHIO: Immediate position available for full-time physician with background in emergency care, family practice, medicine, or surgery in our new emergency facility of 300-bed hospital with complete specialty backup. Paid vacations, malpractice and health insurance, plus pension plan. Contact: Victor Koludrovich, M.D., 12300 McCracken Rd., Garfield Hts., Ohio 44125, phone: 216/581-0500 or 524-7753.

CARDIOLOGIST WANTED: Northwest Ohio. Board certified or eligible to join a busy consulting practice. Performing echos, phonos, treadmill, VCG, Holter, and rehabilitation. Participate in three hospital consultation, C.C.U. and catheterization. Teaching position available. Salary negotiable. Reply to Box 839 c/o Ohio State Medical Journal.

EMERGENCY MEDICINE: Ohio and western Pennsylvania. Occasional part-time or full-time work available. Excellent remuneration and flexible scheduling. Ohio or Pennsylvania license required. Contact: James Ginter, Regional Administrator, 931 Chatham Lane, Columbus, Ohio 43221, phone: 614/457-9761.

HOUSE PHYSICIAN WANTED: For a community hospital located in Northeast Ohio. Attractive fringe benefits, including insurance. Salary negotiable. Must have Ohio licensure. Reply Box 842 c/o Ohio State Medical Journal.

MARION, OHIO: Excellent opportunities in Central Ohio. Existing and new, solo, partnerships, or association practices available and seeking physician support. Top compensation— reliable cross coverage. Exceptionally attractive, 225-bed, well-equipped regional medical center hospital within walking distance from offices. Industry and agriculture support city/45,000; county/65,000; and total trade area/250,-000. Excellent schools and residential areas. Fifty-minute, easy drive to Columbus. Active need for—

FAMILY PRACTICE
INTERNAL MEDICINE
OTOLARYNGOLOGY
PEDIATRICS
INDUSTRIAL/OCCUPATIONAL
EMERGENCY MEDICINE

We are seeking either rural or city-oriented physicians. Send C.V. or contact— **ROBERT FLINT,** Marion General Hospital, **MARION,** OHIO 43302 — or call 614/387-8810 or 387/5442 any time.

ON CRESCENT BEACH!: Deluxe ocean-front two-bedroom condominium on Siesta Key, Sarasota, Florida. Tennis, pool, sandy white beach. For information, write: M.C.-Condo, P.O. Box 2364, Dayton, Ohio 45429.

YOUNG INTERNIST: Born and trained in Ohio, seeks practice opportunity in Cleveland, Columbus, Cincinnati, Dayton or Toledo for July 1979. Reply Box 843 c/o Ohio State Medical Journal.

AMBULATORY CARE CENTER — EMERGENCY DEPARTMENT STAFF PHYSICIAN, ATHENS, OHIO: 20,000 annual patient visits. Flexible scheduling, minimum guarantee/monthly bonus, excellent fringes. Contact Eric Jenison, M.D., O'Bleness Memorial Hospital, Athens, Ohio 45701, or call toll-free 800/325-3982 for details.

FAMILY PHYSICIAN WANTED: Small town in southwestern Ohio. 50 miles from Cincinnati and 50 miles from Columbus. Nice friendly town and large surrounding farming area— collections good. Hospital within ten miles. Practice and fully equipped office. May be bought or leased. Available January 1, 1979. Call 513/780-4424.

CARDIOLOGIST/INTERNIST: Southwestern Ohio group seeks C.V. board-certified/eligible cardiologist to join four cardiologist/internists in the practice of full-range clinical cardiology including invasive procedures. Desire July 1979 availability. Liberal salary and fringe benefits including malpractice insurance. Reply with CV to Box 841 c/o Ohio State Medical Journal.

Journal Advertisers

Bobb Chevrolet Co....771
Brown Pharmaceutical Company, Inc. 740, 784, 785
Burroughs Wellcome Co....744, 772

Code-A-Phone, a Division of Ford Industries....764
Columbus Paramedical, Inc....738

Harding Hospital....787

Immke Circle Leasing....787
International Travel Advisors....792

Lilly, Eli and Company....742

Mead Johnson Pharmaceutical Division 777, 778
Medical Personnel Pool....743
Medical Protective Company....767
Menendian Carpets....781

Ohio Medical Indemnity....789
OSMA Annual Meeting....735, 760

PBP Data Systems....761
Pfizer Pharmaceuticals....782
Physicians Insurance Company of Ohio, Inc....768
PICO Life....757
Practice Productivity....773

R. Lyle Barton and Associates....771
Roche Laboratories, Div. Hoffmann-LaRoche, Inc. ....Cover 2, Cover 3, Cover 4

Smith, Kline and French Labs....758, 759
Stanley H. Kaplan Educational Center...738

Turner & Shepard, Inc....746

Upjohn Pharmaceutical Company....765

Watercolors of Columbus....741
Weight Wise Associates....747
Windsor Hospital....771

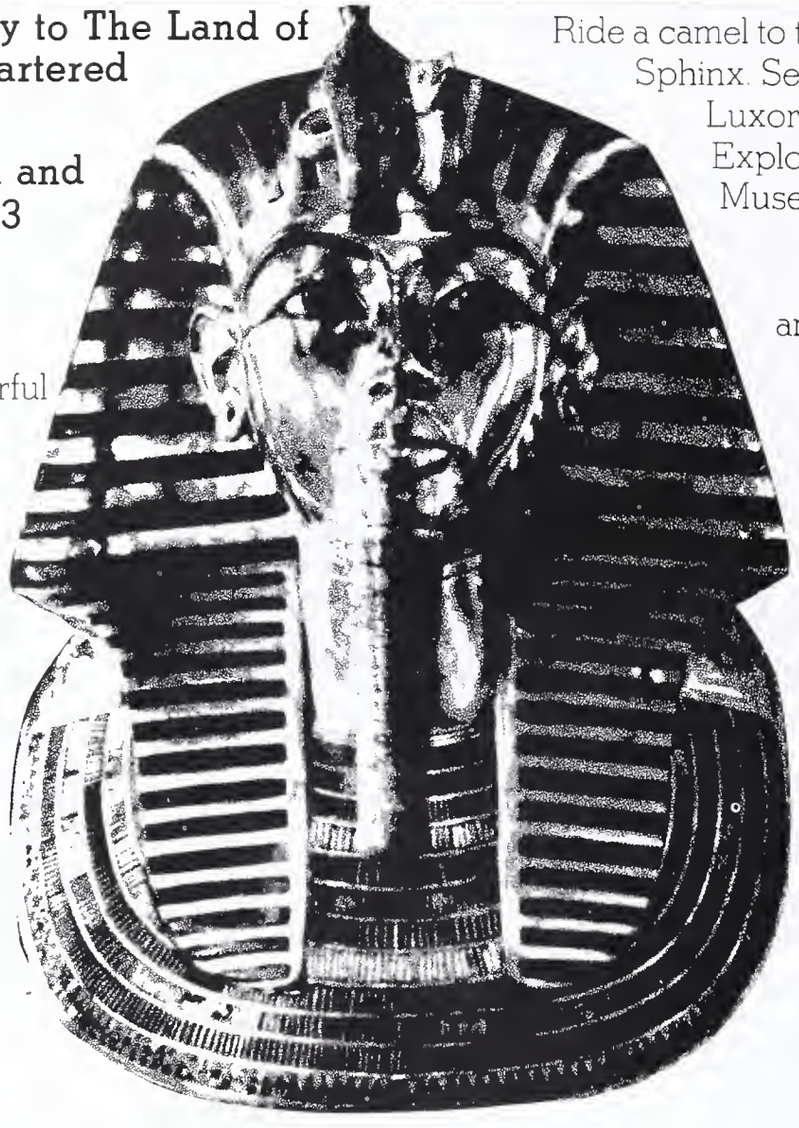
Egypt Adventure

An Eight-Day Holiday to The Land of the Pharaohs Via Chartered World Airways Jet

Departing Cincinnati and Columbus on April 13

$698

No place on earth holds a more fascinating or powerful lure than timeless Egypt. Enjoy one of the world's most sought after and rewarding travel destinations.



Ride a camel to the Pyramids and the silen Sphinx. See the Temples of Karnak a Luxor and the beauty of the Nile Explore the renowned Egyptian Museum, bursting with endles riches. Bargain in Khan E Khalili Bazaar for coppe and brass. And dine on del cious Egyptian delicacies

Don't miss this excitin trip to the Land of th Pharaohs

Send to: Ohio State Medical Association
600 South High Street
Columbus, Ohio 43215
Attn: Miss Catherine Keeling

Enclosed is my check for $ _____ ($100 per person) as deposit.

Names _____

Address _____

City _____ State _____ Zip _____

Area Code _____ Phone _____

Space Strictly Limited-Make Reservations Now

A Non-Regimented INTRAV® Deluxe Adventure

The Ohio State Medical Journal

Index to Volume 74 — 1978

January	Pages 1 to 72	July	Pages 425 to 484
February	Pages 73 to 136	August	Pages 485 to 540
March	Pages 137 to 196	September	Pages 541 to 596
April	Pages 197 to 280	October	Pages 597 to 668
May	Pages 281 to 346	November	Pages 669 to 734
June	Pages 347 to 424	December	Pages 735 to 798

All individuals are doctors of medicine unless noted otherwise.

Authors of Scientific and Socioeconomic Articles

A

ACKERMAN, John H. (Columbus) 149, 157, 623, 639
ASEFF, John N. (Cincinnati) 711
AYISH, Mr. Richard A. (Columbus) 41

B

BACHMAN, David S. (Columbus) 429
BARKLEY, Katherine T. (Cincinnati) 187
BATES, George N. (Toledo) 310
BATLEY, Frank, M.B., Ch.B. (Columbus) 654
BINDER, Sheldon C. (Youngstown) 167
BOMBACH, Jaren D. (Columbus) 23
BOWLUS, Thomas P. (Toledo) 304
BRINKER, Karl R. (Dallas, Tex.) 491
BROWN, Lauren M. (Akron) 29
BUDD, John H. (Cleveland) 13, 350, 531
BUDDEN, James I., M.B.A. (Columbus) 354
BUTTS, Joseph A. (Columbus) 113

C

CLINGER, Mr. Robert D. (Columbus) 602
COBAU, Charles D. (Toledo) 254
CONOMIKES, George S. (Marina del Rey, Calif.) 358
COOK, William M. (Akron) 287
COVER, Evelyn L., D.O. (Columbus) 766
CROFT, Charles C., Sc.D. (Columbus) 157
CRUSE, Robert P., D.O. (Hershey, Pa.) 629

D

DANIELS, Robert S. (Cincinnati) 643
DETTMER, Cornelia M. (Cincinnati) 579
DODSON, Mrs. Gail E. (Columbus) 748
DWYER, Mr. D. Tom (Columbus) 316, 610

E

EATON, Antoinette Parisi (Columbus) 623
ERENBERG, Gerald (Cleveland) 629

F

FOX, Clarence E., J.D. (Columbus) 360
FRIED, Ralph I. (Cleveland) 78
FULTON, Mrs. Joan (Columbus) 769

G

GABEL, Lawrence L., Ph.D. (Columbus) 774
GATES, William H. (Cincinnati) 495
GIRVIN, Mr. Larry (Columbus) 363
GOGATE, Shashi A. (Lancaster) 571
GROSS, Samuel (Cleveland) 118, 287
GUTMAN, Emil (Dayton) 567

H

HALPIN, Thomas J. (Columbus) 149
HAMBRICK, Claude S. (Dayton) 691
HARTMAN, John J., Ph.D. (Ann Arbor, Mich.) 78
HAVENER, William H. (Columbus) 433, 617
HAWK, William A. (Cleveland) 160
HEAD, Mr. William A. (Portsmouth) 366
HENRY, Charles, Ph.D. (Cleveland) 629

I

IRVIN, Mr. John J. (Columbus) 149

J

JAMES, Arthur G. (Columbus) 498, 679
JOHNSON, Duane M., Ph.D. (Atlanta, Ga.) ...370
JOHNSON, Ernest W. (Columbus) 711
JONES, Bruce A. (Columbus) 296
JUGENHEIMER, Kathleen, B.S.N. (Cleveland) 629

K

KAELBLING, Rudolph (deceased) (Columbus) 296
KATZ, Bertram (Youngstown) 167
KEATING, William J. (Fairview Park) 691
KIM, Moon H. (Columbus) 691
KOSE, William H. (Findlay) 691

L

LEWIS, Tom F. (Columbus) 34
LINYEAR, Alice S. (Columbus) 623
LOPEZ, Ivan A. (Massillon) 300

M

MacKENZIE, Aileen L. (Columbus) 412
MALLORY, Thomas H. (Columbus) 23, 636
MARKS, James S. (Columbus) 149
MARQUIS, G. Gregory, CLU (Columbus) 375
MARSHALL, Mrs. W. J. (Dayton) 238
MARTIN, James F. (Huntsville) 412
MAUCK, Mr. Robert S. (Columbus) 381
MAY, Mrs. Ingrid (Marion) 67, 256
METCALF, The Hon. Richard B. (Columbus) ..385
MEYER, Thomas L., Jr. (Columbus) 23
MINTON, John P. (Columbus) 717
MISHLER, William G. (Columbus) 636
MOSHER, J. Harry, CLU (Columbus) 391
MULGREW, D. Brent, J.D. (Columbus) ...42, 545

N

NEWTON, William A. Jr. (Columbus) 438

P

PARISER, Stephen F. (Columbus) 296
PARKER, Milton M. (Columbus) 170
PAUL, William T. (Columbus) 575
PAULSON, George W. (Columbus) ..292, 491, 723
PETREK, Jeanne A. (New York City) 717
POHLMAN, James E., J.D. (Columbus) 395
PORTERFIELD, H. William (Columbus) ...4, 515
PORTERFIELD, Mrs. Linda A. (Columbus) 4, 320, 515, 727, 748
PRESTON, Robert C., J.D. (Columbus) 354

R

RADER, Mr. David L. (Columbus) 398
RAVIN, James G. (Toledo) 78
RAWAT, Arun K., D.Sc. (Toledo) 109
ROCCHI, Ranieri (Toledo) 254
RODIN, Alvin E. (Dayton) 647
ROTHNER, A. David (Cleveland) 629
ROTHRING, Robert G., C.P.A. (Cincinnati) ...400

S

SAUNDERS, William (Columbus) 711
SCOTT, Ronald J. (Lakeview) 142
SHULTZ, John P. (Columbus) 779
SEASON, Edwin H. (Columbus) 691
SFAKIANAKI, Eleni (Columbus) 623
SHAFFER, Thomas E. (Columbus) 563
SIDDALL, A. Clair (Oberlin) 121
SNIDER, Gordon B. (Lancaster) 571
SPRAGG, Carl E. (New Concord) 745
STAPLES, William I. (Cleveland) 118
STEIN, David S., Ph.D. (Columbus) 779
SWETT, Chester P. (Lancaster) 308

T

THOMAS, Robert G. (Elyria) 404
TORRENS, Mr. David C. (Columbus) 748
TYPLIN, Connie L. (Chicago) 563

V

VAETH, Mary F. (Columbus) 639

W

WAGNER, Mr. Michael M. (Columbus) 381
WALSDORF, Jack (Chicago, Ill.) 409
WEBNER, Mr. Neil E. (Columbus) 504
WILLIAMS, J. Hutchison (Columbus) 774
WILLIAMS, Tennyson (Dublin) 29
WISSE, Mrs. Katherine E. (Columbus) 404

Clinical and Scientific Topics

A

A CONCENITAL ANOMALY OF THE RIBS (Emil Cutman) 567
ACUTE LEUKEMIA OF CHILDHOOD AND ADOLESCENCE
(See Cancer Education Series)
AMERICAN COLLECE OF PATHOLOGISTS (See Inspection and Accreditation Program)

C

CANCER COMMITTEE, THE (See Cancer Education Series)
CANCER OF THE BREAST (See How Much Surgery for)
CANCER EDUCATION SERIES
The Cancer Committee (Tom F. Lewis) 34
Acute Leukemia of Childhood and Adolescence (Samuel Cross and Wm. I. Staples) 118
Management of the Cancer Patient in the Community Hospital (Neal J. Prendergast and James C. Maher) 173
Malignant Melanoma (Charles D. Cobau and Ranieri Rocchi) 254
Support of the Cancer Patient and His or Her Family (Thomas P. Bowlus) 304
Cervical Cancer Screening Program Using Papanicolaou's Stain Test (Aileen L. MacKenzie and James F. Martin) 412
Soft Tissue Sarcomas in Children: Surprises! (William A. Newton, Jr.) 438
How Much Surgery for Cancer of the Breast (Arthur G. James) 498
Hospice (Cornelia M. Dettmer) 579
The Case for Conservative Management of Cancer (Frank Batley) 654
CERVICAL CANCER SCREENING (See Cancer Education Series)
CHEST ROENTCENOCRAPHIC SIGNS OF COLLACEN VASCULAR DISEASE (Ronald J. Scott) 142
CLINICAL OBSERVATIONS FOLLOWING PAPAVERINE THERAPY (Cordon B. Snider and Shashi A. Cogate) 571
COLITIS (See Management of Severe Attacks of Ulcerative)
COLLACEN VASCULAR DISEASE (See Chest Roentgenographic Signs of)
COMPARISON OF NATIONAL HEALTH SERVICE SYSTEMS. WHO HAS THE ANSWERS? (Robert S. Daniels) 643
CONSERVATIVE OR RESURFACINC TOTAL HIP REPLACEMENT (William C. Mishler and Thomas H. Mallory) 636
CONTINUINC MEDICAL EDUCATION (See Preparing the Resident for)
(See Estrogen Therapy)
CONTINUINC MEDICAL EDUCATION EXAMINATION 707

D

DATURA STRAMONIUM (See Intoxication by)
DISEASES DESCRIBED BY OHIOANS (George W. Paulson) 723

E

ELEVATION OF SERUM URIC ACID LEVELS IN PATIENTS WITH SEIZURES (George W. Paulson) 292
EMERCENCY MEDICAL CARE (See Prehospital)
ENCEPHALITIS (See St. Louis)
ESTROCEN THERAPY. CONTINUING MEDICAL EDUCATION ARTICLE (Moon H. Kim, Claude S. Hambrick, William J. Keating, William H. Kose, and Edwin H. Season) 691
ESTIMATINC FETAL LUNC MATURITY. A COMPARISON OF L/S RATIO, FOAM STABILITY, AND FETOCRAM (Thomas L. Cross and William M. Cook) 287
ETIOLOCY OF RETINAL DETACHMENT, THE (William H. Havener) 433
EVALUATION OF SURCICAL AND MEDICAL HOSPITALIZATIONS IN COLUMBUS, OHIO (William T. Paul) 575

F

FETAL ALCOHOL SYNDROME METABOLIC ABNORMALITIES (Arun K. Rawat, D.Sc.) 109
FETAL LUNC MATURITY (See Estimating)

G

CENETIC SERVICES IN OHIO. A RECIONAL APPROACH (Antoinette P. Eaton; John H. Ackerman; Alice S. Linyear; and Eleni Sfakianaki) 623
CILLES DE LA TOURETTE'S SYNDROME (David S. Bachman) 429

H

HIP REPLACEMENTS (See Six Hundred Ninety Total . . .)
(See Conservative or Resurfacing)
HOSPICE (Cornelia M. Dettmer) 579
HOSPITALIZATION (See Evaluation of Surgical and Medical Hospitalizations in Columbus, Ohio)
HOW MUCH SURCERY FOR CANCER OF THE BREAST (Arthur C. James) 498
HUMANISTIC MEDICINE. WILLIAM OSLER AND MEDICAL EDUCATION (Alvin E. Rodin) 647

I

IMMUNIZATION (See Status of)
IMMUNOTHERAPY (See Melanoma and Its)
INSPECTION AND ACCREDITATION PROCRAM OF THE COLLECE OF AMERICAN PATHOLOCISTS (William A. Hawk) 160
INTOXICATION BY DATURA STRAMONIUM (Ivan A. Lopez) 300

L

LABORATORY IMPROVEMENT (See Need for)
(See Inspection and Accreditation)
LEUKEMIA, ACUTE (See Cancer Education Series)
LOW SERUM THYROXINE LEVELS
(See Thyroxine-Binding Clobulin Deficiency)

M

MALICNANT MELANOMA (See Cancer Education Series)
MANACEMENT OF THE CANCER PATIENT IN THE COMMUNITY HOSPITAL (Neal J. Prendergast and James C. Maher) 173
MANACEMENT OF RETINAL DETACHMENTS (William H. Havener) 617
MANACEMENT OF SEVERE ATTACKS OF ULCERATIVE COLITIS (Sheldon C. Binder and Betram Katz) 167
MARK ROTHKO'S PAINTINCS—SUICIDE NOTES? (James C. Ravin, John J. Hartman, Ph.D., and Ralph I. Fried) 78
MATERNAL HEALTH IN OHIO
Maternal Mortality Report for Ohio—1974 294
MEDICAL EDUCATION (See Selection of Candidates for)
(See Humanistic Medicine)
MELANOMA (See Cancer Education Series)
MELANOMA AND ITS IMMUNOTHERAPY (Jeanne A. Petrek and John P. Minton) 717
METABOLIC ABNORMALITIES (See Fetal Alcohol Syndrome)

N

NATIONAL HEALTH SERVICE SYSTEMS (See Comparison of)
NEED FOR LABORATORY IMPROVEMENT IN OHIO, THE (John H. Ackerman and Charles C. Croft, Sc.D.) 157

O

OSLER, WILLIAM (See Humanistic Medicine)

P

PAPAVERINE THERAPY (See Clinical Observations Following)
PHYSICAL TREATMENT OF PAIN AND WEAKNESS FOLLOWING RADICAL NECK DISSECTION (Ernest W. Johnson, John N. Aseff, and William Saunders) 711
PREHOSPITAL EMERCENCY MEDICAL CARE (William H. Gates) 495
PREPARINC THE RESIDENT FOR CONTINUINC MEDICAL EDUCATION (Stephen F. Pariser, Bruce A. Jones, and Rudolph Kaelbling) 296
PRIMARY PHYSICIANS (See Survey of Ohio)

R

RADICAL NECK DISSECTION (See Physical Treatment of Pain)
RELATIONSHIP BETWEEN UNEMPLOYMENT AND HEALTH, THE (John H. Ackerman and Mary F. Vaeth) 639
RETINAL DETACHMENT (See Etiology of) (See Management of)
RIBS (See A Congenital Anomaly of the)

S

SARCOMAS (See Soft Tissue)
SELECTION OF CANDIDATES FOR MEDICAL EDUCATION (Milton M. Parker) 170
SIX HUNDRED NINETY TOTAL HIP REPLACEMENTS. A COMPARATIVE STUDY (Thomas H. Mallory, Thomas L. Meyer, Jr., and Jaren D. Bombach) 23
SOFT TISSUE SARCOMAS IN CHILDREN: SURPRISES! (William A. Newton, Jr.) 438
SPORTS MEDICINE (See A Young Physician Looks at the Future of)
STATUS OF IMMUNIZATION OF KINDERCARTEN CHILDREN IN OHIO, THE (Thomas J. Halpin, James S. Marks, John H. Ackerman, M.D., and Mr. John J. Irvin) 149
ST. LOUIS ENCEPHALITIS EPIDEMIC IN OHIO IN 1975 (Ceorge W. Paulson and Karl R. Brinker) 491
SURVEY OF OHIO PRIMARY PHYSICIANS. A PROJECTION OF FUTURE NEEDS TO THE YEAR 2000 (Lauren M. Brown and Tennyson Williams) 29

T

THYROXINE-BINDINC CLOBULIN DEFICIENCY: INNOCENT CAUSE OF LOW SERUM THYROXINE (T_4) LEVELS (Bonnie L. Typlin and Thomas E. Shaffer) 563
TOURETTE'S SYNDROME (See Cilles de la Tourettes)

U

UNEMPLOYMENT (See Relationship Between)
URIC ACID LEVELS (See Elevation of Serum)

V

VALPROIC ACID: A BRIEF REVIEW (Robert P. Cruse, D.O.; A. David Rothner; Cerald Erenberg; Charles Henry, Ph.D.; Kathleen Jugenheimer, B.S.N. 629

Y

YOUNG PHYSICIAN LOOKS AT THE FUTURE OF SPORTS MEDICINE, A (Joseph A. Butts) 113

Socioeconomic Topics

A

Aggressive Moderation — AMA Presidential Address Delivered December 4, 1977 by John H. Budd, M.D., President 13
All Roads Lead to Dayton 201
A Look at IRAs, Keogh, and Corporate Retirement Plans for the Physician (James T. Budden, M.B.A. and Robert C. Preston, J.D.) 354
AMA:
- Address of the President 531
- Drug Abuse Program 100
- Every Physician Needs the AMA 350
- Highlights of the 1977 Interim Meeting 4
- National Leadership Conference 36, 783
- One-Year Dues Reduction for Young Physicians 661
- Presidential Address Dec. 4, 1977 13
- Report of the 1978 Annual Meeting 515

American Academy of Family Physicians Workshop 36
American Express Card, Medical Facilities Accepting 178
AMPHETAMINE ABUSE (The Ohio State Medical Board) 548
Anesthesiologists Sign FTC Order 784
APPOINTMENT SCHEDULING (See Improved)
Arthritis Care Program Open to Ohio Physicians 783
AUTO ACCIDENT BOOKLET 662
AUTOMOBILE (See Leasing)
Auxiliary Involvement in Immunization Campaign (Mrs. Albert May) 256
AXIAL TOMOGRAPHY (See Computerized)

B

Bakke Would Be Rejected Again (AMA News) 616
Best Investment Decision You Will Ever Make, The (Duane M. Johnson, Ph.D.) ...370
Billings and Collections in the Physician's Office (Mr. Robert S. Mauck and Mr. Michael M. Wagner) 381
BLIND, New Pamphlets for 582
BLUE CROSS/BLUE SHIELD OF MICHIGAN, Suit Filed Against 178
BOERSTLER (See George W. Boerstler)

C

CANCER RESEARCH AWARD, Nominations Sought 689
CERTIFICATE-OF-NEED PLANS 509, 661
CHECK LIST FOR NEW OFFICE (Mr. Larry Girvin) 363
CHAMPUS, New Claim Form 689
CHILDBIRTH, New Concept 582
CLASSIFIED ADS 69, 135, 195, 279, 345, 423, 483, 539, 593, 667, 733, 790
COLLEAGUES IN THE NEWS 58, 131, 262, 340, 388, 507, 584, 605, 788
COLLECTIONS (See Billings and)
Computerized Axial Tomography Payment (Mr. D. Tom Dwyer) 610
CONTINUING MEDICAL EDUCATION (CME)
- AMA Publishes List of 1978-1979 Courses 664
- Burroughs Wellcome Company Seminars 65
- Frequent Questions Regarding 762
- Ohio Law Mandates 745-781
- Programs 16, 106, 181, 229-237, 265, 315, 542, 612, 683
- Record of Reregistration 102

COUNTY SOCIETY ROSTER CHANGES 656

D

Death and Dying (Mrs. Joan S. Fulton) 769
Disability Insurance for Physicians (J. Harry Mosher, CLU) 391

E

Energy Shortage 178
ESTATE PLANNING (See Proper)
Every Physician Needs the American Medical Association (John H. Budd) 350

F

FACES (Photographs) 453
FDA (Patient Package Inserts) 662
Financing an Office (See How the Physician Locates and Finances)
Florida Physicians to Advertise on Radio and Television 783
FOREIGN MDs 102
Frequent Questions Regarding Mandatory Continuing Education 762

G

George W. Boerstler, M.B. (1792-1871) First President of the Ohio State Medical Society (Association) (Chester P. Swett) 308

H

History of Homeopathic Medicine at Oberlin, Ohio (A. Clair Siddall) 121
How the Physician Locates and Finances His Office (Robert G. Rothring, C.P.A.) 400

I

Illinois Overturns Limit on Suits 784
Impaired Physician, The 581
Improved Appointment Scheduling and Patient Flow Techniques (Mr. George S. Conomikes) 358
INDEX TO RESOLUTIONS 454
Individual Practice Associations Topic of Regional Seminars 784
Industrial or Occupational Illness 65
INSURANCE (See Major Medical and In-Hospital Insurance)
INSURANCE, LIABILITY (See The Insurance Puzzle)
The Insurance Puzzle: Assembling the Pieces for the Physician's Personal and Professional Protection (Mr. David L. Rader) 398
Insuring Honesty in Your Practice (Mr. Jack Walsdorf) 409
INVESTMENT (See The Best Investment Decision)
IRAs (See A Look at)

J

January 1, 1977-December 31, 1979 the Days of the First Triennial Registration of Ohio Medical Licenses (Mrs. Linda A. Porterfield, Mrs. Gail E. Dodson, and Mr. David C. Torrens) 748
John C. Reeve, M.D., Pioneer Dayton Physician (1826-1920) (Ms. Katherine T. Barkley) 187
JOURNAL ADVERTISERS ..27, 83, 138, 198, 315, 417, 434, 536, 590, 664, 734, 791
JOURNAL MANUSCRIPT GUIDELINES 83, 600, 672, 738
Journal Photographic Exhibit 1979 ....680, 736

K

Keogh and Corporate Retirement (See A Look at IRAs, Keogh)

L

Leasing an Automobile: Advantages to the Physician (Clarence E. Fox, J.D.) 360
LEGISLATIVE UPDATE — Federal 20, 90, 138, 198, 406, 426, 509, 591
LEGISLATIVE UPDATE — State....89, 137, 197, 281, 425, 651, 669, 735
LETTERS TO THE EDITOR 133, 275, 284, 501, 585, 679, 741
LIABILITY INSURANCE (See The Insurance Puzzle)
LIFE INSURANCE (See Primer on)
Locating an Office (See How the Physician Locates)
Lorain County Awards Scholarships 784
Louisiana Medical Malpractice Act Challenged in Courts 783

M

Major Medical and In-Hospital Insurance for the Physician and the Family (Mr. William A. Head) 366
Malpractice Act (See Medical) and (Louisiana)
Manuscript Guidelines 83, 600, 672, 738
Medical Education Via Cable TV 663
Medical Malpractice Act of 1975 — A Retrospect (D. Brent Mulgrew, J.D.) 545
MEDICAL SCHOOL HIGHLIGHTS 337
Medicare Payments Increase 663
MED PRED Library 100
Membership (See OSMA Membership)
Motorcycle Crash Deaths 663

N

National Cancer Institute 65
New Books Received 444
NEW MEMBERS 66, 176, 257, 339, 415, 446, 502, 658, 786
NEWS 178, 260, 333, 419, 442, 534, 581, 661, 727, 783
NOTICE TO ALL OSMA MEMBERS....616, 739

O

OBITUARIES 49, 129, 147, 266, 302, 416, 480, 513, 558, 656, 676, 743
Occupational Medicine Residency 664
Office Personnel (See The Best Investment)
Office Records (See Physicians')
Ohio Academy of Medical History 65
Ohio Medical Indemnity (OMI) 316
Ohio Medical Indemnity Medical Necessity Program (Mr. D. Tom Dwyer) 316
OHIO STATE MEDICAL BOARD 261, 333, 534, 548, 785
OMPAC
- Luncheon 185

OSMA Annual Meeting 59, 132, 201-242
- All Roads Lead to Dayton 201
- Format 203
- Candidates for President-Elect 206
- Delegate and Alternate Schedule 208
- Meal Functions 209
- Members of 1978 House of Delegates 211
- Physicians' Art Show 215
- Social Function 216
- OMPAC Luncheon 217
- Registration Form 218
- Resolutions 220
- Continuing Medical Education Courses 229
- Faces 453
- Index to Resolutions 454
- Proceedings of the House of Delegates 457

OSMA Art Show Winners 582
OSMA Assists Physicians in Meeting the State Mandate (Carl E. Spragg) 745
OSMA AUXILIARY 67, 256, 320
OSMA Auxiliary "Day at the Legislature" (Mrs. Linda A. Porterfield) 320

(Index continued on next page)

OSMA 1978 Budget: Department Analysis 96
OSMA Candidates for President-Elect 206
OSMA County Society Officers, Executive Directors, and Meeting Dates 247
Roster Changes 656
OSMA District Meetings 727
OSMA Fifty-Year Awards 3
OSMA Financial Statements for Years 1976 and 1977 (See Report on)
OSMA Group Term Life Insurance 178
OSMA House of Delegates - Resolutions Deadline 100
Nominations for President-Elect 102
Members 211
OSMA Membership Survey 689
OSMA Membership: You Can't Afford to Be Without It
(Robert G. Thomas and Mrs. Katherine E. Wisse) 404
Notice to All Members 616, 739
OSMA Officers, Councilors, AMA Delegates and Alternate Delegates, and Staff ...475
OSMA Proceedings of the Council 50, 93, 270, 322, 478, 587, 685
OSMA Proceedings of House of Delegates
Dec. 18, 1977 Special Session 86
1978 Annual Meeting 457

P

Physicians' Art Show 215
PHYSICIANS INSURANCE COMPANY (PICO) 61, 102, 310, 419, 689
Physicians' Office Records: Some Medical-Legal Considerations
(James E. Pohlman, J.D.) 395
PLACEMENT SERVICE ADS 72, 193, 342, 540, 665
Planning and Documenting Continuing Education in the Community Hospital
(David S. Stein, Ph.D., and John P. Shultz) 779
PRACTICE MANAGEMENT 350-410
Prescriptions, Presigned 581
Primer on Life Insurance (G Gregory Marquis, CLU) 375
PROFESSIONAL LIABILITY INSURANCE 36
Profile of Medical Practice (7th Edition) 663
Proper Estate Planning for the Physician from the Standpoint of a Probate Judge
(Honorable Richard B. Metcalf) 385

R

RARDIN SCHOLARSHIPS 581
REEVE (See John C. Reeve)
Remarks to Shareholders, Physicians Insurance Company of Ohio
Annual Meeting (George N. Bates) 310
Report of the OSMA District Meetings (Mrs. Linda A. Porterfield) 727
Report on the Examination of Financial Statements for the Years
Ended December 31, 1976 and 1977 541
Report on the First Session of the 112th Ohio General Assembly
(D. Brent Mulgrew, J.D.) 41
RESOLUTIONS, Index to 454
Retirement Plans for the Physician (See A Look at IRAs)

S

Saccharin Restrictions 662
Science Writing Fellowship 65
Scoliosis Screening Program 689
Six Ohioans Receive Outstanding Team Physician Awards 608
Six-Year Biographic Study of Medical Students at the Ohio State University
(Lawrence L. Gabel, Ph.D., and J. Hutchison Williams) 774
STUDENT LOANS 602
Support OSMA . . . Pay Your 1978 Dues 237, 266

T

Team Physician Awards 608
Television Violence and the Child (Mrs. Ingrid May) 67

V

Visually Handicapped Persons' Directory 664

W

What to See and Where to Eat in Dayton (Mrs. W. J. Marshall) 238
Workers' Compensation Bureau Clarifies Consultants' Services
(Mr. Neil E. Webner) 504
WORKERS' COMPENSATION 61, 504

Y

Your Dollars Play Vital Role in Assisting Future Physicians
(Mr. Robert D. Clinger) 602

People

A

ABROMOWITZ, Herman I. 453
ACKERMAN, John H. 453
ADAM, Mahmoud H. 789
AHBEL, Andreas S. 605
ALBERS, John E. 453, 456, 528
ALFIDI, Ralph J. 605
ALTEMEIER, William A. 388
ALTMAN, Michael 262
AMERSBACH, Joseph C. 3
ANDERSON, J. James 474
ANTHONY, Michael A. 262
APLIN, Elizabeth R. 788
ARONOFF, Sen. Stanley J. 320
ASHARE, Alan 788
AVVA, Soma 605
AUKERMAN, Glen F. 605
AYISH, Mr. Richard A. 321

B

BAKER, Mrs. Anne 680
BALIN, Philip L. 262
BANFIELD, William 474
BARNES, Felino 474
BARNES, Nolen T. 3
BARR, David A. 605
BARROWS, Mrs. Emil L. 453
BATATA, Al 340, 605
BATES, George N. 453, 456, 527
BAUER, John C. 608, 609
BAUMANN, Rep. James L. 321
BAUMGARTNER, Donavin A. 474
BAY, William H. 605
BEHARI, Vijay B. 789
BELJAN, John R. 474, 605
BELT, Richard B. 608
BERGER, Thomas S. 453
BERGQUIST, Kaaren H. 605
BERNS, Charles 3
BERNSTEIN, I. Leonard 340
BERSHON, Albert L. 3
BEYER, Millard C. 584
BICKERS, David R. 585
BIRCH, James B. 3
BIRKBECK, Stanley J. 3
BLASS, Norman H. 340
BLUM, Leonard A. 3
BLUM, Otto W. 3
BOFINGER, K. Kurt 262
BOGNAR, Rudolph 3
BOLTON, Barrett H. 788
BOWMAN, Harold J. 679
BOWMAN, James A., Jr. 58, 584
BOYLES, Jack 456
BRALLIAR, Thomas B. 340, 606
BROOKS, Dennis 340
BROWN, Edith P. 3
BROWN, Owen L. 262
BROWNING, Robert H. 3
BRUMBAUGH, John D. 3
BRUST, Albert A. 507
BRYANT, James 607
BUCK, John F. 3
BUCKLES, Maurice G. 3
BUDD, John H. 4, 10, 13, 14, 58, 86, 216, 453, 456, 515, 520, 532
BUDD, Mrs. John H. 453, 456, 526
BUDD, Mr. John H. Jr. 532
BULLOCK, John D. 788
BURK, Richard H. 131
BUSAM, Paul A. 606
BUSH, Everett M. 789

C

CACCAMO, Leonard P. 584
CALVERT, James Wm. S. 3
CAMARDESE, Nino M. 86
CANDELA, Richard 388
CARTER, Eunice R. 605
CASTELE, Theodore J. 9, 87, 474, 528
CERELLI, James 340, 605
CHALFIN, Lewis W. 3
CHAMBERS, Clint 788
CHAMBERS, David A. 3
CHANDNANI, Prem C. 388
CHASE, Joseph E. 680
CHEN, Mao-Hsung 388
CHIASSON, Simon W. 131
CHRISTMAN, Rep. Larry H. 320, 456
CLAPPER, Henry H. 453
CLARKE, Oscar W. 9, 50, 453, 519
CLORAN, Arthur J., D.D.S. 456
COHEN, Alan M. 605
COHEN, Terry L. 605, 606
COHN, Phillip 3
COMERFORD, Thomas J. 789
COMPTON, Helen J. S. 3
COMPTON, William C. 3
COOPER, Merlin L. 3
CRAMBLETT, Henry G. 131
CRAWFORD, Henry A. 3
CRILE, George Jr. 388, 679

D

DAVIES, A. Robert 340
DAVIS, Lee Roy 789
DAWSON, Alan D., Lt. Col., USAF, MC 453
DEME, Charles D. 3

People

DENNY, William L. 3
DE PIERO, Nicholas G. 456
DESAI, Privakant 788
DIDIO, Liberato J. A. 507
DORNER, Arthur F. 3
DOSICK, Steven M. 453
DUNLEA, Frederick W. 388
DUNSKER, Stewart B. 474, 520
DUSINA, Mr. Joe 453

E

EBSWORTH, Mr. Barney 50
ELLICK, Lawrence R. 58, 584
ELLISON, Mrs. Jayne 131
EMERY, William M. 608, 609
ESPINIELLA, Jose 788
EVANS, Arthur T. 788

F

FALKNER, Frank 131, 606
FARMER, Richard G. 788
FEGELMAN, Ronald H. 788
FISHER, Joseph E. 606
FIX, Rep. Helen H. 320
FLEEGLER, Earl J. 262
FLEMING, James E. 788
FORD, C. Douglass 456
FOX, Harry H. 456
FOX, Thomas E. 478, 527, 606
FRALEY, Mrs. Beth 453
FRANK, George H. 519
FRANZ, Martha 606, 607
FRASURE, Mr. Mark 58
FREDERICK, Kenneth A. 605
FREEMAN, Elias 474
FRIEDELL, Hymer L. 605
FRIEDL, Edward P. 3
FRYE, Carl 453
FULLERTON, Hobart R. 3
FUHLBRIGGE, Armin R. 605
FULTON, Richard L. 456, 527
FUMIERE, Michelle 340

G

GAETH, Sen. M. Ben 320
GANDY, Roland A., Jr. 456
GANIM, Mitchell N. 3
GANS, Howard M. 3
GARDIKES, Arthur 607
GARDNER, W. James 584
GATES, William H. 456
GAUGHN, John J. 58, 453, 456, 474, 519
GAUGHN, Mrs. John J. 456
GAVAN, Thomas L. 340
GERHARDT, William J. 262, 606
GERSTNER, Patsy A. 607
GHORY, Joseph 262
GIANNESTRAS, Nicholas K. 131
GIFFORD, Ray W. 340
GILES, Howard DeB. 3
GILLEN, Mr. Herbert E. 456, 522
GILLEN, John C. 507
GILLETTE, Robert 340
GLASS, Virgil S. 3
GOLDEN, Ronald B. 584
GOOD, James C. 58
GRABLE, Edward E. 474, 527
GRETTER, Thomas E. 262
GREVER, Michael 584
GRIBBIN, Edward A. 3
GROTHJAN, Cletus A. 3
GUJU, John G. 131
GUPTA, Satyendra 606

H

HALE, Rep. Phale D. 321
HALL, Sen. Tony 456
HAMBRICK, Claude S. 340
HAMILTON, Ian G. 3
HAMILTON, John M. 3
HAMMON, Jerry L. 9, 520, 528
HAMOR, Robert H. 58
HAN, Bokyung K. 788
HANBY, Wallace B. 584
HANGER, Irwin C. 3
HARDIE, James A. 341
HARDY, Russel 507
HARDYMON, Phillip B. 474
HARRIS, Stephen A. 3
HARTLE, Richard E. 456
HARTWELL, Shattuck 606
HASHIMOTO, Kenneth 131
HAYNES, Ralph E. 606
HEER, George J. 3
HEIMLICH, Henry J. 388
HEINE, Walter F. 3
HESS, John H. 3
HEUPLER, Frederick A. Jr. 789
HICKSON, David J. 456
HILDEBRAND, Roy D. 3
HINES, Harry K. 9
HO, Edmund P. 605
HOCHWALT, William R. 3
HOGG, Stephen P. 456
HOLCOLM, Mr. Robert E. 456
HOLDEN, Henry 388
HORESH, Arthur J. 3
HOSKINS, Charles R. 3
HOWLAND, Willard J. 131
HUBBELL, Donald 58, 584
HUDSON, Raymond B. 3
HUDSON, William E. 608, 609
HUFF, A. Burney 474
HUNT, John H. 3
HUNTER, Robert B. 516
HUSNI, Elias 606
HUSTON, John 388

I

ICENHOWER, Mrs. Irene 453
INKLEY, Scott R. 341, 788
IRISH, Everett A. 3
IRIZARRY-CONCEPCION, Tomas H. 788

J

JACOBY, William D. 262
JAGODZINSKI, James 388
JAMES, Harold M. 3
JELENKO, Carl III 606
JENNINGS, F. Lamont 340
JHUNJHUNWALA, Jagadish S. 607
JOFFE, C. David 340, 788
JOHNSON, John C. 606
JOHNSON, J. Walter 3
JUVANCIC, Richard W. 606

K

KACALIEFF, Louis D. 507
KAHN, Sherman E. 131
KEATING, William I. 453
KELLERMEYER, Robert W. 507
KENNEDY, K. W. 58
KENYON, Rex E. 518
KHULLAR, Subhash C. 789
KILROY, Edward G. 474
KIMURA, Kazou K. 789
KING, Richard L. 262
KLEIN, Charles M. 388
KOH, Jae M. 605
KOHNER, Ernest 3
KRAMER, Howard X. 131
KROMPASZKY, Tibor 3
KRONE, Robert E. 606
KUMIN, Harry J. 3
KUNKEL, Robert S. 606
KURSH, Elroy 607
KUSTER, Austin H. 58
KWON, Y. Joe 679

L

LA MAIDA, Vincent T. 453, 456
LAMPERT, Virginia L. 788
LANCIONE, Peter A. 131
LANDT, Harry E. 3
LAO, Edward E. H. 789
LAUVA, Janis 605
LAVIN, Thomas J. 340
LEE, S. Christopher 606
LEFF, Arnold M. 584
LEICHT, George P. 474
LEIMBACH, Warren H. 341
LEMIEUX, Bernard J. 605
LEPORE, Vincent D. 131
LEVER, Harry M. 789
LEVIN, Solomon 341, 507
LEVY, D. H. 388
LEVY, Richard P. 262
LEWIS, William J. 9, 453, 456, 518
LIEBER, Maurice F. 131
LIEBERMAN, Hyman S. 3
LIGHT, Theodore L. 474
LINCKE, Carl A. 474
LINDOWER, John O. 789
LOGSDON, Robert E. 474
LOHR, Lawrence J. 3
LONCENECKER, Douglas P. 605
LOWENDORF, Chester S. 3
LUBENS, Herman M. 607
LUBIN, David 3
LUCAS, Stanley J. 456
LUCIANO, Mr. Robert P. 65
LUKEN, Robert R. 605
LYON, Paul E. 456, 474

M

McCANN, John N. 3
McCARTHY, Justin E. 3
McCORMACK, Lawrence J. 789
McCORMISH, Cletus T. 3
McDONALD, John S. 585
McGOVERN, Mark 262
McGOWEN, Charles H. 607
McLARNAN, James C. 453
McLARNAN, Mrs. James C. 453
MACKIW, Theodore 3
MacMILLAN, James E. 262
MAGENHEIM, Herbert G. 474
MAGGIED, Sol 206
MAGNUSON, Robert H. 507
MAHAN, Alfred C. 3
MALONE, Charles 58
MAREK, James J. 3
MARINO, Salvator G. 3
MARKS, Jack 341
MARTIN, J. B. 608, 609
MARTIN, Joseph P. 58, 584
MARTINBEAU, Pierre W. 584
MAY, Albert 474
MAY, Mrs. Albert 453, 474
MEANEY, Thomas F. 585

(Index continued on next page)

People

MEDALIE, Jack H. 585
MEILING, Richard L. 607
MELNICK, John G. 388
MENNINGER, Karl A. 520
MERRYMAN, William B. 789
MESHALI, Homayoun 605, 607
MEYER, Tearle L. 341
MILLER, Roy 605
MILLESON, Sen. Kinsey 320
MILLS, Harold F. 474
MINNING, Carl A. 58
MOHLER, Stanley 789
MONTGOMERY, David M. 507
MORGAN, Thomas W. 58, 207, 453, 526
MORROW, Grant III 607
MOUNTS, Robert J. 262
MUELLER, Walter 3
MULGREW, D. Brent, J.D. 41, 321, 456
MURDOCK, Rep. Norman A. 321
MURRAY, James A. 474
MURRAY, Mr. Richard 321

N

NEIDUS, Morris W. 3
NEILSON, Dave 474
NELSON, Gordon G. 3
NESBITT, Tom E. 515
NESBITT, Mrs. Tom E. 526
NEWLAND, Harry 507
NOVAK, Mr. Robert D. 474

O

OGASEK, Sen. Oliver 321
OCKULY, Eugene A. 3
OHANESSIAN, Simon 789
OLDENBURG, Frederick A. 789
OLMSTED, Levona W. 788
OLSON, Stanley W. 788
OMELSKY, Louisa E. Lorber 3
ORR, James M. 58
OSBORN, Arthur L. 3
OTIS, James J. 453

P

PAGE, Mr. Hart F. 50, 474, 522
PANAYIDES, Marios 605
PARK, Dong S. 605
PARROTT, Max H. 10
PARRY, Thayer L. 3
PATTERSON, James A. 605
PAUL, William 321
PAULE, Cornelius J. A. 3
PEREZ, Louis M. 4
PESGOVITZ, Harold 474
PETERS, Calvin R. 341
PIGARD, Gustav G. 3
PIGHETTE, G. Edward 456
PICHETTE, David E. 388
PICKETT, George E. 65
PITNER, Samuel E. 607
PORTERFIELD, H. William 9, 86, 131, 453, 518
PRITCHARD, Walter H. 788

Q

QUADER, Azher 788
QUILTER, Rep. Barney 321

R

RADECKI, Gasimir 3
RANDALL, Asher 388
RATH, Ranjit 456
RAVEL, Vikram A. 788
RAYPORT, Mark 507
REAMY, H. Judson 131, 453, 605
REDDING, Ms. Barbara 65
REED, Albert H. 3
REED, Benjamin H., Jr. 456
REMPES, Mr. Howard C. Jr. 453
RIDDLE, Bedford N. 3
RINDERKNEGHT, Robert E. 58, 474
RIVER, George L. 388
ROBART, Wilbur G. 3
ROBECHEK, P. John 9, 519
ROBINSON, Harry H. 3
ROOF, Glyde S. 3
ROSENBLUM, Max H. 3
RUDY, David 507
RUNDELL, William K. 607
RUPPERSBERG, Anthony J. 131, 262

S

SAFDI, Stuart A. 606
SAGEBIEL, James L. 3
SALCEDO, Eresto E. 789
SANDERS, John H. 453
SANFELIPPO, Lt. Gol. Peter 788
SAVILLE, Mr. George H. 676
SCHAFFER, Gerry 585
SGHALLER, William H. 3
SCHAUER, John W. 3
SGHLEMMER, John P. 789
SCHOCK, H. Charles 3
SCHRADIN, Leslie J. 3
SGHREIBER, Jack 9, 453, 528
SGHRIMPF, Cyril E. 3
SCHULTZ, John P. 607
SGHULTZ, Joseph 58
SCHWAB, Louis 607
SGHWARTZ, David C. 789
SGOTT, David R. 3
SELNICK, William B. 453
SHAFER, Alan 607
SHAW, James M. 58, 584
SHEEHAN, Mark 585
SHIVELY, Frank L. 607
SHOMAN, Alfred F. 262
SHORTEN, Edward A. 388
SIDDALL, A. Clair 607
SILLS, Theodore H. 3
SIRIPONG, Pannee 788
SITTERLY, Brooks H. 606
SKILLERN, Penn G. 58
SLAGER, Richard F. 262
SLOAN, William Reach 607
SLOMER, Norbert F. 3
SMITH, Leonard K. 456, 474
SMITH, Robert N. 9, 453, 474
SONES, F. Mason 516
SOTOS, Juan F. 607
SOVIC, William E. 453
SPENGER, N. Carman 3
SPENCER, Mr. Robert 456
SPITZ, Harold B. 262
SPRAGUE, David W. 262
SPRAGUE, Edward A. 262
ST. CLAIR, Peggy Jeanne 474
STEINER, James H. 474
STEINREIGH, Otto S. 789
STERNAN, Edward F. 585
STEWART, Dudley M. 3
STRYKER, William B. 3
SUGARMAN, Sigmund R. 788
SWANGER, Ronald F. 341
SWETT, Chester P. 607
SZENTENDREY, Laszlo 3

T

TABRAH, Farouk A. J. 789
TAMARKIN, Saul J. 3
TETALMAN, Mark R. 262
TEW, John M. Jr. 388, 507
THOMAS, James J. 474
THOMAS, Robert G. 453, 526
THOMAS, Russel 507
THOMPSON, Carl G., Jr. 456, 474
THORNTON, Thomas G. 341, 606
TIMPERMAN, Albert 507
TOLBERT, Herman A. 341
TRANTER, Rep. Terry M. 321
TSGHANZ, Robert E. 584, 788
TUCKERMAN, Warren W. 86
TURNBULL, Rupert B. Jr. 388
TURNER, John J. 388
TWIGGS, Donald B. 605

U

UGKER, David A. 341
ULRIGH, Robert P. 262
UNGER, Frances 607
UY, Santos A. Jr. 789

V

VAN BUREN, Ronald C. 605
VAN DER HOVEN, Ludolph H. 474
VAN EPPS, Kenneth 58
VARGAS, Belen P. 788
VICTOROFF, Victor 507
VILTER, Richard W. 388
VUKSTA, John E. 605
VUKSTA, Michael J. 608, 609

W

WALTHER, John W. 131
WARNOCK, Robert G. 388
WASYLYSHYN, Rostyslow J. 607
WEDDINGTON, Wilbur H. 605
WEICKENAND, Walter J. 3
WEIDENMIER, Carl H. 3
WEISER, Richard W. 3
WELLMEIER, Hugh 3
WELLS, William M. 50, 87, 453, 474
WELLS, Mrs. William M. 453
WELSH, Frank 607
WENZEL, Richard L. 585
WHITACRE, James F. 3
WHITE, Robert J. 58
WILLIAMS, Tennyson 605
WINANS, Theodore H. 3
WINTER, Chester C. 789
WISE, Henry A. II 789
WISELY, Richard 456
WITTEL, Ronald 131
WROBLEWSKI, Mr. David 585

Y

YAMAGUCHI, Ben T. 606
YODER, John R. 262
YOUNG, Robert S. 789
YUBERO, Mr. Fernando L. 741
YUBERO, Gerardo 741
YUT, Joseph P. 789

Z

ZEEK-MINNING, Pearl 3
ZICKES, John J. 3
ZOLLINGER, Robert M. 3

☆☆☆

1174 S

344281